STI/HIV/AIDS PREVENTION AND CONTROL IN NICARAGUA:

NEEDS ASSESSMENT

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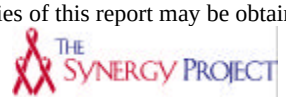

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ACRONYMS AND FOREIGN TERMS

AIDS	Acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
ALAFA	Alianza Latinoamericana par la Familia
AMNLAE	Asociación de Mujeres Nicaragüenses “Luisa Amanda Espinoza”
BCC	Behavior change communication
CBD	Community-based distribution
CDC	Centers for Disease Control and Prevention
CEDOC	Communications center (part of CISAS)
CIES	Centro de Investigación y Estudios en Salud
CISAS	Health Information, Services and Advisory Center
CMF	Centro Mujer y Familia
CSM	Condom social marketing
DFID	Department for International Development (United Kingdom)
DHS	Demographic Health Survey
DIMECOSA	Division of PROFAMILIA funded by USAID/Nicaragua
FHI	Family Health International
HIV	Human immunodeficiency virus
ICAS	Central American Health Institute
ICASO	International Council of AIDS Service Organizations
IEC	Information, education and communication
ILPES	Instituto Latinoamericano de Prevención y Educación en Salud
LACCASO	Latin American and Caribbean Council of AIDS Service Organizations
MCH	Maternal and child health
MINSA	Ministerio de Salud (MOH)
MOH	Ministry of Health
MSM	Males who have sex with males
NACP	National AIDS Control Program
NGO	Nongovernmental organization
NORAD	Norwegian Agency for International Development
OIM	Organización Internacional para las Migraciones
PAHO	Pan American Health Organization
PASCA	Programa Acción SIDA de Centro America
PASMO	Pan-American Social Marketing Organization
PSI	Population Services International
PEN	National strategic plan
PLWHA	Persons living with HIV/AIDS
PNCS	National AIDS Prevention and Control Program
PROFAMILIA	Nicaraguan Family Planning Affiliate
RAAN	Northern Autonomous Atlantic Region
RAAS	Southern Autonomous Atlantic Region
SILAIS	Sistema local integral de salud
SNVE	National epidemiological surveillance system
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

A needs and resource assessment regarding human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) was carried out from February 7 to 18, 2000, in order to inform future planning for the United States Agency for International Development (USAID/Nicaragua). The Mission was a full participant in this assessment and over 30 key individuals and agencies were interviewed. It is clear that while epidemiological data are not yet available to assess adequately the stage of the epidemic in the country, all of the preconditions for a serious epidemic are in place. Among the most salient factors which create this situation are:

- a belief in all sectors of the population that HIV is not a problem in the country;
- an absence of governmental commitment for prevention and care;
- a lack of HIV surveillance data which might inform the general population as well as program planners and policymakers;
- serious epidemics in bordering countries (Costa Rica and Honduras) with mobile populations crossing these borders on a regular basis;
- post–Hurricane Mitch conditions, including trauma and destabilization of communities;
- normative high-risk sexual practices;
- lack of a "condom culture";
- unemployment affecting commercial sex and poverty;
- stigmatization of high-risk behavior groups, such as female sex workers and males who have sex with males (MSM); and,
- the stigma of HIV and AIDS, which prevents treatment, counseling, testing, and care services.

At the same time, Nicaragua has many resources that could provide a strong basis for supporting surveillance, prevention, and care activities with improved organization and coordination. These resources include:

- a progressive national human rights law;

- trained medical personnel (currently underused or in other sectors);

- a large number of health and development nongovernmental (NGOs) in the country, many of which are headed by individuals in national leadership roles;

- established national NGO networks and NGOs experienced in training and preventive education; and,

- the international donor community is willing and able to collaborate with USAID to maximize funding and support in the area of HIV/AIDS.

HIV/AIDS IN NICARAGUA

Ten years of a low-intensity war and an economic embargo isolated Nicaragua and produced a delayed appearance of HIV. But the available data on HIV/AIDS in Latin America and the Caribbean show a striking diversity in epidemic patterns between and within countries. While Nicaragua's epidemic started at a different point in time from other countries in the region, it is increasingly affected by their epidemics. Economic, social, political, and cultural factors, along with geography, now combine to set all the necessary preconditions for a serious epidemic which will move from the current concentration in high-risk behavior populations to replicating the generalized epidemics of its neighbors, especially Honduras.

Nicaragua's epidemic is mainly sexually driven, followed by injecting drug use, transfusions, and perinatal transmission. The epidemic is concentrated in urban populations; Managua and Chinandega account for 58 percent of all cases. In December 1999, Nicaragua's estimated population of 4.9 million had an AIDS incidence density of 0.72 cases/100,000. The cumulative reported number of seropositive cases was 511, of whom 236 had developed AIDS and 134 had died.

The Pan American Health Organization classifies HIV/AIDS epidemics in three stages: (1) nascent, in which prevalence is less than 5 percent in the population at risk; (2) concentrated, in which prevalence is greater than 5 percent among the population at risk and less than 1 percent among the general population; and, (3) generalized, in which prevalence is greater than 1 percent among the general population. The 1999 rates suggest that prevalence in the general population is less than 1 percent, placing the country at the level of a nascent epidemic. However, Nicaragua is likely to progress rapidly to the level of a concentrated epidemic due to numerous factors:

- **Displacement due to war and disaster:** Because of the trauma and disruption of lives and families, natural disaster profoundly increases susceptibility to both physical and mental illness. Hurricane Mitch-affected communities clearly have increased risk of infection. For example, a recent field visit to Somotillo, on the

Honduran border, found groups of 90–120 crossing the border, 265 sex workers, and no condoms available. The breakdown of traditional behavioral norms, the new survival behaviors that result, the formation of new types of relationships, and new contacts and opportunities may place individuals and families at risk for disease, especially sexually transmitted diseases.

- **Prostitution:** The commercial sex trade is growing in areas with a high concentration of transient workers; as in most poor countries with high unemployment, women who lack skills or support for their children often perceive prostitution as their only recourse.

- **Gay populations**: As a hidden population in a country where a "condom culture" does not yet exist and where homosexuality is forbidden by the church and penalized by the state, gay men are highly vulnerable to HIV. Men who do not identify themselves as gay but are bisexual or heterosexually identified are even more hidden—but these are the men of greatest concern in HIV prevention because they are the bridge from MSM and heterosexual communities to a generalized epidemic infecting women.

- **Migrants and mobile populations:** These groups are extremely vulnerable to HIV/AIDS, not only due to their low education and level of information, but the fact that the majority are labor migrants who return periodically to their place of origin. Emigration from Nicaragua is increasing due to the lack of economic opportunities in the country, and many families have chosen migration as a survival strategy. Moreover, Nicaragua is not only a sender country, but also a transit country; not only does the Pan American Highway go through the country, but the many borders provide well-used routes for mobile populations, including truckers and sex workers.

- **Youth:** Nearly half (43 percent) of Nicaragua's population is under 15 years of age. Like the rest of Latin America, the Catholic Church and Christian evangelical groups vigorously support traditional norms and ideas antagonistic to HIV/AIDS prevention education and activities. In Nicaragua, however, the Church and its cardinal are exceptionally powerful forces that influence every aspect of life. Without better approaches toward the content of sex education, this large adolescent population will continue to receive negligible information about sexually transmitted infection (STI) and HIV prevention. Nicaragua urgently needs a sexual education program for adolescents in order to achieve long-term HIV prevention and technical assistance to design a high-quality program and assist in negotiation with high-level politicians and the Catholic Church.

- **Lack of a condom culture:** Since HIV/AIDS after infection has no cure, and virtually no one infected in less developed countries has access to the expensive and difficult drug therapies, prevention is the only realistic response. Preventing HIV transmission occurs through prompt diagnosis and treatment of STIs and behavior change, including the correct and consistent use of condoms by individuals at risk of infection. Unfortunately, Nicaragua does not have a condom use culture. The 1998 Demographic and Health Survey (DHS) found that only 1.6 percent of sexually active men reported using condoms occasionally.

RESOURCES

Nongovernmental Organizations

The situation of nongovernmental and community-based organizations in Nicaragua is unique and complex and affords an HIV prevention and care initiative with enormous resources and challenges at the same time. The NGO sector varies in capacity and has a large concentration of former public officials and political leaders, necessitating careful selection of partners who can carry out successful projects. At the same time, NGOs exist all over the country; many have wide networks that can reach urban, rural, and mobile populations and groups practicing high-risk behaviors. Groups involved in HIV/AIDS work range in focus from almost entirely concentrated in HIV/AIDS to those taking a small role in research or prevention with specific target populations. The extraordinary range and number of agencies is an important resource for HIV–prevention planning.

Donors

The new director of the Pan American Health Organization (PAHO) in Nicaragua came to the country with 20 years of experience in African countries heavily affected by AIDS. He has said "the epidemic trend is reliable and alarming," noting that "there is not only one epidemic in the country, there are several, and the only advantage Nicaraguans have is time." Norway, through the Norwegian Agency for International Development (NORAD), has given PAHO a $750,000 three-year grant to stimulate intersectoral coordination and promote social communication. He also observed that "there is a false reliability in unsolid figures," referring to the low number of confirmed AIDS cases and the lack of information that suggests the epidemic in Nicaragua has low priority. PAHO has initiated discussions with donors, the United Nations, the Ministry of Health, and NGOs on HIV/AIDS issues. With USAID, the Ministry of Health and the Joint United Nations Programme on HIV/AIDS (UNAIDS) are undertaking a revision of the government's national strategic plan to address the epidemic.

USAID RESPONSES TO HIV/AIDS IN NICARAGUA

USAID/Nicaragua

USAID/Nicaragua began supporting modest bilateral HIV/AIDS efforts in 1995, when the Mission provided some funding to the Bureau for Global Programs, Field Support and Research (Global Bureau) AIDS Control and Prevention Project (AIDSCAP) project to develop HIV/AIDS prevention programs, strengthen the capacity of local institutions and NGOs to implement HIV/AIDS control and prevention efforts, and establish the concept of self-vulnerability among segmented audiences. Since then, the Mission has received funds earmarked for HIV/AIDS activities in the range of $250,000–500,000 a year as part of the Mission's ongoing child survival allocation; the Mission expects funding in this range to continue.

Currently, the Mission's largest HIV/AIDS interventions occur through its ongoing condom social marketing (CSM) effort. The USAID/Nicaragua–funded DIMECOSA division of PROFAMILIA sells Bodyguard condoms targeted at youth, primarily for the prevention of unwanted pregnancy, but also for HIV/AIDS prevention. PROFAMILIA launched the Bodyguard condom in March 2000 and sold over 500,000 in the first three weeks of the campaign, far exceeding targets. Since the campaign began, more than 2,000 new, nontraditional outlets nationwide began selling Bodyguard condoms, including groceries (pulperias), cafeterias (comedors), and shops and stalls near the Zona Franca assembly plants (maquiladoras).

In fiscal year 2000, USAID/Nicaragua received $500,000 in HIV/AIDS funds. The Mission allocated this money to the Johns Hopkins Population Communications Services project to support CSM and public education on HIV/AIDS through the media and to make a small subgrant to Nimehuatzin, a leading NGO that is wholly dedicated to HIV/AIDS issues. Nimehuatzin will use the grant to launch a targeted program in Chinandega, the site of Nicaragua's second largest concentration of HIV/AIDS cases.

USAID Regional Program

The USAID Central American HIV/AIDS Prevention Project, managed out of the regional USAID Mission located in Guatemala, has two components: (1) the Programa Accion SIDA de Centro America (PASCA), which supports policy dialogue and NGO strengthening; and (2) the Pan-American Social Marketing Organization (PASMO), which markets the HIV/AIDS condom VIVE throughout the region. The current four-year regional HIVS/AIDS program ends in 2002; the regional Mission has proposed a new four-year strategy, which is now under review in the Bureau for Latin America and the Caribbean (LAC).

USAID/Washington

USAID's Global Bureau's Center for Population, Health and Nutrition (PHN) Strategic Support Objective in HIV/AIDS is "increased use of improved, effective, and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic." The Office of Health and Nutrition in the PHN Center supports projects worldwide that address priority HIV/AIDS issues, provide technical assistance, training and field support for a broad range of initiatives, including behavioral and operations research, epidemiological surveillance, policy dialogue, and advocacy.

APPLYING WORLDWIDE EXPERIENCE TO NICARAGUA

Worldwide lessons learned for USAID/Nicaragua efforts to address HIV/AIDS are clear:

- Integrated, multidisciplinary, multisectoral and multilevel approaches are best. The health sector alone cannot manage the multifaceted determinants and impacts of HIV/AIDS; sustainable prevention, care, and support programs require a broader development framework. Poverty, political disenfranchisement, gender discrimination, and lack of political will both impede successful interventions and reinforce risk-producing situations. Successful intersectoral efforts require a broad coalition between governmental and nongovernmental agencies, men and women, adults and youth, and service providers.

- Individuals with multiple sexual partners are particularly vulnerable to STIs, transmit the infection to others, and play a significant role in maintaining high STI rates. It is expedient to target STI services and prevention activities to them.

- Comprehensive approaches are more effective than isolated interventions. Strategies for preventing sexual transmission of HIV should include increasing access to and demand for condoms, mainly through condom social marketing programs; reducing sexual risk through behavior change communication (BCC); and, treating and controlling STIs.

- The design, implementation, and evaluation of HIV/AIDS intervention activities should apply crosscutting issues, such as human rights, gender, youth, community ownership, sustainability, and local capacity building.

GENERAL STRATEGIC PRINCIPLES TO ADDRESS HIV/AIDS

1. Act as soon as possible.

Early in an epidemic, HIV spreads exponentially. Because few people are infected, the probability is low that unprotected sex involving an infected person and a random partner will result in a new infection. A prevention campaign, focusing on the high-risk behavior and vulnerable population can significantly reduce the transmission rate among members of these subgroups and ultimately, to members of the general population.

2. Change the highest risk behaviors.

The HIV epidemic is largely influenced by the amount of mixing between people with different practices of risky behavior. Preventing HIV infection in someone with a high rate of partner change will indirectly avert many more future infections than preventing an infection in a person who practices low-risk behavior, has fewer partners, and is therefore less likely to infect others.

3. Use the most cost-effective approaches.

Prevention of infection among those with the highest rates of partner change has a large effect. Also, increasing rates of condom use among those with high rates of partner change, as well as focusing condom subsidies and promotion efforts on changing the behavior of these groups, is likely to be highly cost-effective.

4. Prevent HIV sexual transmission.

Global strategies to prevent sexual transmission of HIV have focused on three primary approaches: increasing access to and demand for condoms, mainly through condom social marketing programs; reducing sexual risk through BCC; and, treating and controlling STIs. STIs have long been implicated as a co-factor for HIV transmission; people with current or past STIs are 2–9 times more likely to be infected with HIV.

5. Use both behavioral and biomedical interventions.

The distinction between behavioral and biomedical interventions for STI prevention is artificial, since both are required; in fact, they are complementary. Biomedical interventions are ineffective without behavioral components to support them; behavioral approaches must address all factors responsible for sustaining transmission. Interdisciplinary approaches are therefore essential.

PROPOSED STRUCTURE FOR AN EXPANDED BILATERAL PROGRAM

OBJECTIVE: INCREASED USE AND IMPROVED QUALITY OF HIV/AIDS INFORMATION AND SERVICES

Key decision-makers and the general public need to understand more fully HIV/AIDS in Nicaragua and support ethical, quality activities in prevention, care, and support.

Strengthening HIV/AIDS institutional partners, increasing visible government support for HIV/AIDS services, and improving coordination will facilitate technically sound, cost-effective activities. Major stakeholders in HIV/AIDS prevention should be strengthened. In the public sector, the national AIDS/STI control program needs strengthening at both the central and regional levels. In the private sector, NGO participation in HIV/AIDS prevention, care, and support should be expanded and their technical quality, management capability, and sustainability strengthened. In line with these priorities, then, an approach that addresses the following five issues is recommended:

- policy strengthening,
- data collection and surveillance,
- diagnosis and treatment of sexually transmitted diseases,
- behavior change in high-risk behavior groups and adolescents, and
- condom social marketing.

To address these issues, USAID/Nicaragua needs to have a strong, direct role in donor coordination and policy dialogue. A tripartite implementation strategy is envisioned:

- **Strengthening the government response:** Technical assistance, funding, training, monitoring, supervision, and evaluation will be needed to develop or expand the following areas according to the above strategies: surveillance, STI diagnosis and treatment, HIV counseling and testing, laboratory strengthening, biosafety, care for people living with HIV, and behavioral change communication among adolescents.

- **Strengthening and expanding the response of nongovernmental organizations:** Technical assistance and financial resources will be needed to research, design, implement, and evaluate BCC interventions focused in high-risk behavior groups. In addition, NGOs should help in policy development and advocacy, particularly related to HIV/AIDS and human rights.

- **A flexible small grants program to fill gaps and encourage innovation.**

CONCLUSION

With new bilateral funding, USAID will be the largest donor for HIV/AIDS prevention in the country. This position is a crucial window of opportunity to help to prevent a generalized HIV/AIDS epidemic in Nicaragua.

I. INTRODUCTION

PURPOSE AND METHODOLOGY

The purpose of this review is to assess the conditions of the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) epidemic in Nicaragua by exploring the availability, accessibility, and utilization of HIV/AIDS services and interventions to prevent sexually transmitted infections (STI) at the community, nongovernmental organization (NGO), and governmental levels.

This needs and resource assessment regarding HIV/AIDS in Nicaragua was carried out from February 7 to 18, 2000, by a team composed of Dr. Jorge Sanchez (epidemiologist and infectious disease specialist) who acted as the team leader; Dr. Michele Shedlin (medical anthropologist); and, Dr. Alberto Araica, United States Agency for International Development (USAID)/Nicaragua officer. Mr. Clifton Cortez, USAID/Washington, joined the team for the second week.[1]

A comprehensive assessment was conducted using interviews, site visits, observations, and review of available documents. A participatory process that seeks input from key stakeholders was used. The original plan was for the team to visit key individuals and agencies in Managua and three states. However, the agenda was modified by the team for a number of reasons, including the priority given to HIV/AIDS policy activities taking place in Managua during the period of the assessment visit. Thus, interviews with provincial NGOs were limited to contacts made with their personnel attending these activities in Managua. In addition to the full participation of Dr. Araica for the entire visit, the Mission took an active interest in all aspects of the assessment.

BACKGROUND

According to the 1998 Demographic and Health Survey (DHS), Nicaragua has a population of 4,806,700, with 43 percent less than 15 years of age. Fifty-nine percent of the population live in urban areas. Nicaragua has three natural geographic zones: Pacific, North-Central, and Atlantic. There are 15 departments within these zones (each with its capital city), in addition to two autonomous regions (the Northern Autonomous Atlantic Region [RAAN] and the Southern Autonomous Atlantic Region [RAAS]) in the Atlantic zone.

[1] Douglas Heisler, Stan Terrell (both from USAID), and Ann Fitzgerald (from the Programa Acción SIDA de Centro America [PASCA]) supported the team with their visit and feedback.

Economic and Demographic Characteristics

Thirty-one percent of the households are headed by women. Almost 30 percent of women reported some physical or sexual abuse. Less than half the population has had some primary education while less than one fourth has had any secondary education.

Female sterilization is the most used method of contraception in a population that had a 60 percent user rate at the time of the survey. For every 1,000 children born in the country, 17 die within a month and an additional 22 die before their first year. The Atlantic area has both the highest fertility rates and the highest infant mortality.

Nicaragua is an extremely poor country, with an estimated per capita income of $465. The economy is predominantly agricultural, dependent on sugar, beef, coffee, and seafood exports, with some light manufacturing. The economy grew an estimated 5 percent in 1997—the fourth year of growth after a decade of contraction. The inflation rate was about 8 percent. The unemployment rate was officially estimated at 14 percent, with underemployment reaching 35 percent. Private investment increased, but was hindered by the slow resolution of long-standing property disputes stemming from massive confiscation by the Sandinista government of the 1980's (U.S. Department of State, 1997).

Status of the HIV/AIDS Epidemic

The available data on HIV/AIDS in Latin America and the Caribbean show a striking diversity in epidemic patterns between and within countries. In fact, Nicaragua is an example of a country where the epidemic has started at a different point in time from other countries in the region and which is becoming increasingly affected by their epidemics. While historical factors were important in delaying the epidemic in Nicaragua, economic, social, political, and cultural factors, along with geography, now combine to set **all the necessary preconditions for a serious epidemic**, which will move from the current concentration in high-risk behavior populations to the generalized epidemics of its neighbors.

AIDS was detected in Nicaragua much later than in other Latin American countries, even though multiple sexual partners and sexually transmitted infections (STIs) are common. Ten years of a low-intensity war and an economic embargo isolated Nicaragua, resulting in a delayed appearance of HIV. A 30-year-old man was the first AIDS case diagnosed in Nicaragua in 1987. Election of the UNO party in 1990 restored diplomatic and trade relations with other countries, resulting in a large influx of repatriates and refugees from countries with a high HIV prevalence. With an estimated population of 4.9 million in 1999, the AIDS incidence density that year was 0.72 cases per 100,000 population. The cumulative number of reported seropositive individuals through December 1999 was 511, of whom 236 had developed AIDS and 134 had died.

The epidemic is predominantly sexually driven, followed by intravenous drug use, transfusions, and perinatal transmission. Transmission is facilitated by a declining economy, a growing commercial sex trade in areas with a high concentration of transient workers, and a large homosexual and bisexual population. In addition, an increase in the number of infected women has been reported. The epidemic is concentrated in the main urban and economic centers; Managua and Chinandega account for 58 percent of all AIDS cases.

According to mathematical modeling, it is estimated that in the year 2000 about 24,600 individuals will already be infected with HIV, and that the incidence would range between 260 and 790 new infections per 100,000 inhabitants.

These numbers must be understood within the context that **no HIV epidemiologic surveillance system** is in place and **no data on HIV prevalence in the general population are available.** During 1996, with the support of the AIDS Control and Prevention (AIDSCAP) project, considerable effort was made by the Ministry of Health (MOH) to develop a prevalence study among female sex workers and males who have sex with males (MSM) in Managua, Corinto, and Bluefields. Available data from the 1996 survey indicate that HIV prevalence among female sex workers was less than 1 percent in Managua, Corinto, and Bluefields) and 1.5 percent among MSM in Managua.

With these rates, an assumption can be made that the prevalence in the general population is less than 1 percent, and according to the World Bank classification of HIV epidemics, Nicaragua is at the level of a nascent epidemic. It should be noted, however, that incidence data indicate a rapid progression to the level of a concentrated epidemic due to numerous factors, among which are the high and generalized incidence of poverty, cultural patterns of machismo, lack of scientific sex education, and migration to and from other countries with generalized epidemics. The individuals most affected are in the 20–44 year age group, who make up the economically active population.

Various studies indicate that the general population has a basic knowledge about HIV/AIDS and the use of condoms, but in practice, condom use is very low. According to the DHS report (April 1999), 6 of every 10 women know they can prevent getting HIV by using a condom and one fourth think that they can prevent the virus by having only one sexual partner. These numbers are similar to the answers given by the men—65 and 22 percent, respectively. Nine percent of the women believe that they are at great risk while 6 percent believe that they are at moderate risk. The men see themselves at slightly greater risk—20 and 11 percent, respectively.

In 1995, USAID/Nicaragua provided support for AIDSCAP to develop an HIV/AIDS prevention program, build the capacity of local institutions to implement HIV/AIDS control and prevention efforts, and establish the concept of self-vulnerability among segmented

audiences. HIV/AIDS information through mass media is said to have reached about 450,000 people. Approximately 800 people were trained to deliver HIV/AIDS–prevention messages.

Projected Statistics, Year 2000

According to a report presented by the MOH regarding the projected impact of HIV/AIDS in Nicaragua in the year 2000, the following situation will prevail.

HIV Infection

- There will be between 8,100–24,000 new HIV–seropositive individuals.
- Prevalence will be between 260–790 per 100,000 people.
- The greatest proportion of infected individuals will be 15–39 years of age, with the incidence among women being greater than that among men.
- Ten to 31 new cases will be reported weekly.

Economic Impacts of HIV and AIDS

- Private industry will be affected by the epidemic due to absenteeism of a patient and/or family member, replacement of qualified workers and the job training that will be required, insurance payments and other services to which a worker is entitled, and decreased productivity.
- The average number of years lost will be 28.8 (43 percent) for men and 36.3 (52 percent) for women.
- The average number of productive years of an infected person will be 6.8 and of a noninfected person, it will be 30; the difference is a loss of 23 productive years.
- The projected economic impact due to hospital care required for the year 2000 is between US $1.6–4.8 million.
- It is estimated that the country will lose US $44,500 in income per infected person.
- Estimated macroeconomic loss is calculated to be between US $61–185 million.
- Each family will fail to receive approximately $32,432 in salaries that the person with AIDS will not receive, exacerbating an already difficult economic situation.

Social Impact of HIV and AIDS

- Approximately 650–2,000 children will be orphans, presenting related social problems for whom neither the state nor the families will have the capacity to assume responsibility.

The National Program for the Prevention and Control of STIs and HIV

The National Program for the Prevention and Control of STIs and HIV (NACP) of the Ministry of Health was established in 1998. The program is operating under its fifth director. This amount of change has caused a break in operational continuity at least every two years.

The program is part of the General Directorate of Hygiene and Epidemiology (under a director who is a medical epidemiologist), which is part of the General Directorate of Health Services of the Ministry of Health. The national program is decentralized operationally by the local systems of integrated health care (SILAIS) at the departmental level. The SILAIS vertically coordinate STI/HIV prevention, control, and education with regional hospitals and primary care health centers and health posts. At this level, the two principal functions are coordinated by the epidemiologists: information, education and communication (IEC) work plans are elaborated to be submitted to the national program for funding and intersectoral collaboration is established with key stakeholders to integrate and complement prevention activities.

In addition to the director, the program has two support positions: an IEC specialist and an STI surveillance specialist. At the management level, the program is funded by the government and various donors. These funds are administered by the General Directorate of Hygiene and Epidemiology and are assigned locally, depending on the priorities of the program.

The most important accomplishments of the program to date are the national strategic plan for the prevention of STIs/HIV, and the management of the Program of School Health, which coordinates educational activities in the schools. The process of strategic planning in the country was begun in 1998 under the initiative of the Ministry of Health by the national program with the technical assistance of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Programa Acción SIDA de Centro America (PASCA). (See the section on the strategic plan.) By agreement of the Ministerio de Salud (MINSA) and CONISIDA, the plan will provide the reference point for the diverse partners nationally to respond to the AIDS epidemic in Nicaragua.

Currently, four priorities have been identified for the national program:

1. Revise the strategic plan at all levels,
2. Strengthen epidemiological surveillance,
3. Improve the quality and confidentiality of services to vulnerable populations, and
4. Implement the school health program, focusing on STI/HIV prevention.

II. CONTEXT OF THE EPIDEMIC

SOCIOPOLITICAL CONTEXT: SALIENT FACTORS FOR RESPONSES TO HIV/AIDS

Historical Factors

Experts believe that a combination of events has retarded the epidemic in Nicaragua. From 1979–90, the country was involved in an eight-year civil war and faced a U.S. economic embargo (1985). Nicaragua was in semi-isolation; there were only a limited number of visitors from other countries in addition to Cuban and Soviet advisers. With the change in government in 1990, Nicaragua was opened up to more international contact. Individuals have arrived or returned from areas where HIV was more prevalent, such as Honduras and the United States.

Nicaragua has suffered more that its share of disasters, including earthquakes and recently, Hurricane Mitch. These events are part of the country's history, culture, and experience as a nation. The effects of a major earthquake in 1972 can still be seen in the country's capital and in the population's reluctance to name its streets. The effects of Hurricane Mitch have and will continue to have serious effects for some of the country's most vulnerable populations. Mitch caused catastrophic floods and landslides and left hundreds of thousands of Nicaraguans without food or shelter. Many of Mitch's victims were poor subsistence farmers living in Nicaragua's northern agricultural regions or migrant farm workers in the central highlands. Large numbers of people are now unemployed and do not have any resources available for the purchase of food and basic supplies.

The municipal sector was also severely affected. Approximately 70 municipalities (of a total of 147) suffered major impact to physical infrastructure. Damage to the health sector was devastating. Potable water and wastewater systems serving an estimated 804,000 people suffered over $560 million worth of damage; some were destroyed completely. Ninety health centers and more than 400 health posts were harmed. Damage to the education sector was extensive. Disease prevention in communities at high risk of suffering from the spread of malaria, dengue, cholera, and leptospirosis is a serious concern.

Because of the trauma and disruption of lives and families, the displacement of peoples due to war and disaster has a profound effect on their susceptibility to both physical and mental illness. Environmental conditions of temporary housing, the lack of sanitation, clean water, food and other daily needs are only the most obvious of the threats to health and well-being. However, there are many other factors which need to be considered, such as the breakdown of traditional behavioral norms, the new survival behaviors which result, the formation of new types of relationships, and new contacts and opportunities which may place individuals

and families at risk for disease, among which are STIs. Refugees and displaced people are especially vulnerable to sexual exploitation. Relief agency personnel worldwide acknowledge that "exploitive sex is inextricably linked to survival" (Siecus, 1998). And historically, refugee camps and settlements of displaced persons have recorded extremely high fertility rates where families are renewing life and replacing loss, and where reproductive health services and contraception are lacking as well.

While relief efforts have emphasized the immediate needs of housing, water, and sanitation as well as attention to such diseases as diarrhea, malaria, and respiratory illnesses, HIV prevention has been considered a secondary issue as it has been in other refugee situations. Given the emerging epidemic in the country, the high rate of STIs in the areas affected by Mitch, and the risk factors inherent in poverty and dislocation, Mitch-affected communities are clearly at increased risk for HIV infection.

The Role of the Church and Immediate Concerns

The Church and its cardinal in Nicaragua are powerful forces in every aspect of Nicaraguan life. Even the Nicaraguan Revolution, unlike the secular uprisings of Mexico and Cuba, counted on the support of the religious communities of the country. As in the entire region, however, the Catholic Church, Opus Dei, and various Christian evangelical groups are forces in maintaining traditional norms and ideas, which are antagonistic to HIV/AIDS prevention education and activities.

In the case of Nicaragua, it is clear that the Church has a controlling influence on policy, especially with certain ministries, such as the Ministry of the Family. Currently, this ministry appears to be wresting control of all sex education from the Ministry of Education. However, even the morality and dogma expressed in the existing Ministry of Education materials regarding sex education are repressive, such as the official booklet provided to the assessment team by the vice minister of education, *Política de Educación de la Sexualidad*. This booklet blames the "abandonment of traditional morality" on European and North American culture (especially Hollywood), gays, international organizations, and NGOs. Furthermore, sex education curricula developed by church-influenced organizations are currently being readied for adoption. PROFAMILIA has received a copy of the proposed curriculum and has warned USAID about its dangers. Should the Church continue to control the content of sex education, STI/HIV prevention for the country's adolescent population (43 percent of the population is under 15 years of age) will continue to be negligible.

Human Rights Law and Regulation

Law No. 238, "Promotion, Protection and Defense of Human Rights in relation to AIDS," was passed by the National Assembly on September 26, 1996; was ratified by the president on October 14, 1996; and, was published in La Gaceta (official government publication) on

December 6, 1996. This is an extremely progressive human rights law and is a model for the region. The new government took office in January 1997, and in May, work was begun by the Red de Etíca to draft a strategy to put the law into practice (reglamento). Concurrently, PASCA funded a number of individuals and agencies to develop a regulation of the law. The original version of the draft regulation prepared by Nimehuatzin and the national AIDS control program (NACP) was presented to the minister of the presidency. In the meantime, the PASCA version was held up for unrelated political reasons. The PASCA representatives then contacted the medical adviser to the Health Commission of the National Assembly, which resulted in this version being approved by the Assembly.

The following are the most commonly voiced concerns about this regulation:

- It was based on a conceptualization of the law as an HIV/AIDS law rather than as a human rights law—a law that relates to the whole of society, not only to persons living with HIV/AIDS (PLWHAs).

- Serious legal contradictions exist between the law and the regulation.

- Law No. 238 was seen as a means of changing society's attitudes and behavior without needing to impose penalties—the regulation is one in which individuals and institutions are penalized for noncompliance.

- A multidisciplinary approach was not followed as it had been with the formulation of the law; that is, the opportunity was not used to educate policymakers and increase their sensitivity, and the process was confined to a small number of individuals with specific agendas.

HIGH-RISK BEHAVIOR GROUPS AND ENVIRONMENTS

Sex Workers

Prostitution is legal in Nicaragua; brothels were present until the Sandinista government abolished them. As in most poor countries with high unemployment, prostitution is perceived as the only recourse for women who have no employment skills or other support for their children. Studies of sex workers in the country reveal that drugs appear to be increasingly involved in prostitution and are easily available in Managua and the port cities. Alcohol, cocaine, and crack have been shown to be routinely used by clients and increasingly by the sex workers themselves. Injection is not yet reported as a common practice although some injection drug use has been identified. Sex workers report condom use with clients but not with partners.

Gay-Identified and Other Males who have Sex with Males

Article 240 of the Penal Code considers homosexuality to be a crime because of the behavior of sodomy. This appears to be one of the bases of discrimination in the country, along with the strong influence of the churches.

There are no gay communities, other than networks of men who meet, socialize, and communicate informally. Few gay clubs exist (only in Managua), and those that have any visibility are routinely closed by police under many pretenses. While some women-led nongovernmental organizations (NGOs) may identify as serving the gay community, the only gay male organization with any history in the country, CEPSIDA, remained small, was directed at HIV prevention, and is now defunct.

The gay populations in Managua and other cities appear fragmented by age, social status, and sexual behavior. Those unidentified (solapado) are both activo and pasivo, hiding their sexual preference from a society which they consider strongly machista and homophobic. As a hidden population, in a country where a "condom culture" does not yet exist and where homosexuality is forbidden by the church and penalized by the state, gay men are highly vulnerable to HIV. Non-gay-identified, bisexual, or heterosexually identified men, are even more of a hidden population in this context. It is clearly these men who bridge the MSM and heterosexual communities that are of major concern in HIV prevention, especially since they are the bridge to a generalized epidemic.

Mobile Populations

Not only does the Pan American Highway go through the country, but the many borders provide well-used routes for mobile populations, including truckers and sex workers who do a circuit of countries before returning home periodically.

The Dirección General de Migración y Extranjería reported the movement of 1,692,950 people during 1998, among nationals and foreigners who have entered or left the country (legally) at different points. Sixty-six percent of tourists come from Central America, principally Honduras, Costa Rica, El Salvador, Guatemala, and Panama, in order of importance. From North America, the figure is 20.5 percent (mostly from the United States). More than 8 percent are from Europe. Even though the tourist industry is just beginning, it is third in income for the country and is an important issue to consider in relation to HIV–transmission possibilities. The (legal) movement of nationals in 1998 showed 805,893 departures and arrivals, only 26 percent by air. Much of this movement was for employment in Costa Rica or the United States. Uneven economic development, such as that between Costa Rica and Nicaragua, fosters movement of workers especially across that border. The majority of those migrating by ground transportation do so without documents; these numbers are not registered.

Most of the internal movement is to and from Managua; interdepartmental movement is usually for seasonal work. There are also other mobile groups, including shrimp and lobster fishermen, small-scale merchants who move between border towns and the interior, as well as those in contact with international drug trafficking. Drug-related HIV infection has already begun to be registered (Arauz et al., 1997).

Given the HIV epidemics in Honduras, Costa Rica, and the United States (Miami), and the internal movement within the country, the issue of mobile populations and HIV is especially salient. Because mobile populations are mobile, and because different groups are moving between different internal and external points where HIV is a more serious issue, it is not only their risk behaviors that pose a problem for primary prevention.

Ethnic Minorities

Composing about 6 percent of the country's population, the indigenous people live primarily in the Northern Autonomous Atlantic Region (RAAN) and Southern Autonomous Atlantic Region (RAAS), created in 1987 out of the former department of Zelaya, which border the Caribbean Sea and make up 47 percent of the national territory. According to the government's May 1995 census (which undercounted the population by as much as 25 percent in some rural areas), the four major identifiable tribes are the Miskito (with approximately 140,000 members), the Sumo (15,000), the Garifuna (1,500), and the Rama (1,000).

These areas are among the poorest in the country, lacking sources of employment and infrastructure of any kind. Many communities are hard to reach and have no medical care. STI rates and infant mortality are among the highest in the region. Drugs are common because of the proximity of many ports and narcotics traffic. Drug use by adolescents has been documented both in and out of schools. Cases of HIV and AIDS are already being registered and no care is available.

The many cultures, languages, extreme homophobia, difficult access, illiteracy, and health status of the communities pose serious prevention obstacles.

NATIONAL STRATEGIC PLAN (PEN)

The process of strategic planning in Nicaragua was initiated at the beginning of 1998 at the suggestion of the MOH through the National AIDS Prevention and Control Program (PNCS) with technical assistance from the Joint United Nations Programme on HIV/AIDS in Nicaragua (UNAIDS/Nicaragua) and its regional advisor. In this process, consultation meetings were held with diverse organizations from the Civic Society and other government offices who work in the area of HIV/AIDS. PASCA was invited to provide technical support.

A work group was established to coordinate the activities related to the process. This group was made up of the director of the PNCS, who was named the coordinator of the team; a representative of the National Commission on AIDS of the Civic Society; and a representative of the sistema local de atención integral (SILAI) of Managua. This team was to receive technical and strategic planning support from UNAIDS/Nicaragua and policy development support from PASCA. A process for preparing the strategic plan was developed, which included a preliminary analysis of the situation of HIV/AIDS, a review of lessons learned, and identification of internal and external stakeholders to be included in the process. Additionally, a chronological work plan was developed along with a budget that would be shared by UNAIDS and PASCA.

A consultant was contracted from one of the NGO organizations working in HIV/AIDS who arranged interviews and focus groups. Because of circumstances related to the internal working of the MOH (i.e., change of minister) and other concomitant events, the process of strategic planning stalled. In the first trimester of 1999, in order to reinitiate the planning process, UNAIDS and PASCA suggested that the coordinating group submit the completed working documents on the situational analysis that was completed and the validation by sectors who had participated in its formulation (interviews and focus groups). A multisectoral meeting took place with more than 40 people attending. Again, the process stalled, exacerbated by the departure of the director of the NACP and coordinator of the planning team.

The director of PNCS reinitiated the planning process. PASCA incorporated the modifications suggested in the situational analysis and response. The multisectoral meeting for the formulation of the PEN took place in October 1999, for which UNAIDS and PASCA provided additional technical assistance through three Central American regional coordinators.

The PEN was publicly presented on December 1, 1999, in a ceremony presided over by the vice minister of health.

In order to establish an integral approach to STI/HIV/AIDS, the following eight strategies were considered:

- strengthen the collaborative networks that already exist,
- influence the definition of national policies on STI/HIV/AIDS as a public health problem fostering prevention and integrated services,
- design and implement activities to solicit and obtain financial resources, permitting implementation of the national strategic plan,

- design and implement an IEC program,
- develop a national blood bank program that guarantees a safe blood supply,
- strengthen the national epidemiological surveillance system (SNVE) to include STI/HIV/AIDS at all levels and health subsectors in the country,
- design and implement an integrated service model for PLWHAs, and
- design and implement an integrated plan of services for pregnant women living with HIV/AIDS.

Although the eight strategies established are important and essential for a national program designed to prevent the spread of STI/HIV/AIDS, the key elements missing that would make the plan more viable and effective are a diagnosis and treatment system and a system for increased access to and demand for condoms, mainly through condom social marketing programs.

In addition, the PEN should incorporate several crucial crosscutting issues into the design, implementation, and evaluation of the activities:

- human rights,
- gender,
- youth,
- sustainability,
- community ownership, and
- local capacity.

It is also important to note that interviews with UNAIDS and some of the NGOs revealed serious dissatisfaction with the process and the plan itself. Many key stakeholders felt left out; participants themselves, when interviewed, were not satisfied with the technical quality of the plan or the document; and, other NGOs and individuals expressed dissatisfaction with the process and content (see appendix D, Interview Summaries). Importantly, most expressed concern that this strategic planning document included an operational component directing future activities and designating recipients for funding.

III. NEEDS IN NICARAGUA

POLICY DIALOGUE

The national AIDS control program (NACP), along with programs addressing tuberculosis, cholera, and leprosy, fall under the Division of Infectious Diseases, one of five subdivisions of the MOH General Directory of Environmental Health and Epidemiology. The NACP director, a general practitioner, supervises two technical staff, a nurse in charge of epidemiology, and an educator. This team focuses on implementing activities and delivering some services, but has dedicated little effort to national level coordination and has just begun policy development activities. Because of its low rank within the ministry hierarchy, the NACP lacks influence over other ministries regarding HIV–prevention activities; no other ministry has a formal strategy to respond to the epidemic. In the past, the MOH has simply elaborated five-year medium-term plans proposed by PAHO. Recently, UNAIDS recommended efforts to develop the national HIV/AIDS strategic planning process, with financial and technical support from PASCA, the USAID regionally funded program.

Nicaragua's highly politicized, violent, and polarized history has produced living conditions that present all the traits of a generalized but unacknowledged posttraumatic stress disorder. But in this context, the country is now trying to develop its nascent democracy. Nicaragua's important NGO sector largely consists of former public officials and/or political leaders, some of whom have adjusted to their new roles and some of whom have not. Nicaragua's HIV/AIDS situation is no exception. For this reason, careful selection of local partners who can contribute to successful projects and carry out meaningful activities is essential.

There are bureaucratic hurdles to policy development within the Nicaraguan public sector that are not seen in the policy development and advocacy work of the NGO sector. One Nicaraguan NGO, Nimehuatzin, has been very active in policy development and advocacy, particularly related to HIV/AIDS and human rights. Nimehuatzin offers sophisticated policy development and advocacy experience in addition to access to high-level policymakers and elected officials.

DATA COLLECTION

HIV Case Reporting System and Data Management

The reporting system in Nicaragua uses the 1990 Caracas HIV case definition. Codes are used for reporting at the regional and national levels. However, at the local level, the names of HIV–infected individuals are available to the epidemiology office, making confidentiality unrealistic. Also, a policy of contact tracing of HIV cases is in place. The reports are entered in an Epi Info database at the national level; no analysis is conducted at the regional level.

The number of reported HIV asymptomatic infections is very low, which reflects a lack of HIV voluntary counseling and testing services available in the country.

An evaluation of the current case definition as well as the implementation of a reporting system that guarantees confidentiality is needed.

Epidemiologic Surveillance

No STI/HIV sentinel surveillance for low- or high-risk behavior groups is in place in Nicaragua. Implementation of a national sentinel surveillance system integrated with the regional sentinel surveillance system would facilitate understanding of the epidemic.

A PASCA initiative has been proposed to develop a regional sentinel surveillance system for female sex workers and MSM in capital and port cities. This multicentric approach aims to establish a system that provides decision-makers with accurate and reliable information about the epidemic and updated information on an annual basis. The information would be suitable for making informed decisions about setting priorities for resource allocation and the design of targeted interventions. The study expects to contribute to the formation and strengthening of a Central American cadre of experts who will ensure continuous surveillance into the future. This activity has been designed to be a collaborative effort between PASCA; the Ministries of Health of Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama; the Center for AIDS and STD at the University of Washington; UNAIDS; the Pan American Health Organization (PAHO); the U.S. Centers for Disease Control and Prevention (CDC); and, several local NGOs.

This initiative could be complemented with a sentinel surveillance system for pregnant women between 15–24 years of age as a surrogate group of the general population.

Operational Research and Evaluation Plan

Despite the efforts in the second generation sentinel surveillance, there is an obvious lack of information for an understanding of behaviors in different populations, sexual networks, epidemiological bridges between populations, migration, health-seeking behaviors, quality of STI services, and availability and quality of condoms. The design and implementation of research that addresses these topics should be important outcomes for the future USAID bilateral project in Nicaragua. Technical assistance for behavioral research will be needed to assure integration of quantitative and qualitative research.

Also urgently needed is the development of an evaluation plan that identifies not only process indicators but also outcomes, intermediate outcomes, and impact indicators. The evaluation plan should describe indicator definitions, data sources, purposes, and limitations of each indicator.

STI/HIV SERVICES

National Guidelines and Norms

The National AIDS Control Program guidelines were developed in 1994. The guidelines include norms on etiologic STI management, HIV testing and management, and administrative procedures. There is no evidence of protection of confidentiality or voluntary testing in these norms.

The counseling national guidelines, edited in 1993, include topics on pre- and posttest HIV counseling but STI counseling is not addressed.

There is a clear need for revision and updating of the national guidelines according to Law No. 238 and its regulation and state-of-the-art strategies for STI/HIV prevention and control.

Training

The needs assessment team was told that a 3–day course for syndromic management of STIs is available at the NACP upon funding of donors. Six out of 17 SILAIS have received training in syndromic management for some of their health care providers. The course uses PAHO's curriculum for syndromic management training; however, no adaptation to the local reality was attempted. The training provided through the MOH is the same that is available for the NGOs.

A 2–day course for HIV counseling and testing is available through the Ministry of Health. All the SILAIS have received at least one course on counseling. However, NACP personnel do not believe this is sufficient.

The needs assessment team was unable to participate in any of the courses regularly provided by the MOH or to evaluate the facilitators of these courses. No training for HIV management is available.

STI Services

The provision of accessible, acceptable, and effective care services is a cornerstone of any program for the control of STIs. In most developing countries, patients seek care from a mixture of public and private sources, and in many countries, most STI care is obtained outside the public sector.

There are no data in Nicaragua to aid in understanding the proportion of STI care provided by the private sector. However, it is expected that a large proportion of STI patients seek care with private physicians, NGOs, and pharmacies.

NGOs reported using syndromic management to provide STI services. However, STI care providers do not prescribe adequate drugs and sometimes mix etiologic management with syndromic management.

The MOH in Nicaragua, according to NACP officers, currently offers STI clinical services in 6 out of 17 SILAIS using syndromic management. The evaluation team had the opportunity to visit three health centers in Managua. The personnel at the health centers had knowledge of the procedures for syndromic management; however, logistics for the patients are not adequate and, as the health personnel reported, "treatments provided for free by the government are not always available or are not first choice for the pathogens involved in the syndrome to be treated." In addition, condoms and IEC materials to support prevention education and behavior change were not available.

Although it is recommended that STI services be integrated into primary health care clinics, clinics specializing in STIs may be useful in providing primary care in urban settings for specific groups, such as sex workers and their clients, migrant workers, truckers, and other groups with poor access to health care. Additionally, because of a concentration of STI expertise, these clinics can offer referral services for primary care services, hospital outpatient departments, and private practitioners. Furthermore, the specialized clinics can be strengthened as reference centers to provide health care providers with training in STIs, epidemiological information, and operational research. There is no reference or specialized STI clinic in Nicaragua.

No national protocol of STI services for female sex workers is in place. Most go to public or NGO STI service centers and receive syndromic management. Since many STIs are asymptomatic in female sex workers, laboratory testing is required for a recommended STI management in this population. Only one NGO provides this service under a grant supported by the Department for International Development (DFID); this service is provided once or twice a year as a mass campaign.

Counseling Services and Voluntary HIV Testing

There is a lack of an STI/HIV counseling and voluntary HIV testing system in the country. The MOH provides counseling through the public health care system. However, during site visits, counselors were not available either because of the high turnover of health personnel or because they needed to accomplish other tasks in the establishments. There is no infrastructure for counseling services in the health services; counseling sessions are not a regular service and are available only upon request.

HIV testing is provided in different health centers. However, almost all of them only take blood samples and send them to the regional or national laboratory. In some regions, because of the lack of laboratory supplies, HIV testing requires the approval of the head of

the epidemiology office at the SILAIS, making the process for obtaining an HIV test very difficult. A big concern during this process is the lack of confidentiality in HIV testing, expressed by different PLWHAs.

HIV Clinical Services

There are no services for HIV/AIDS clients in Nicaragua. Rafael Butrago National Hospital used to provided clinical services to HIV−infected patients.

No highly effective antiretroviral therapy is available. Supposedly, the government provided for free tuberculosis and Pneumocystis carinii prophylaxis. However, the accessibility of HIV clients to this service is a concern; only one NGO provided clinical services to PLWHAs.

The needs assessment team carried out four interviews with PLWHAs to elicit some of their perceived resources for and obstacles to prevention and care. Gay and heterosexual men and a housewife now working with the Red de Etíca were interviewed.

The interviewees presented different risk histories but many of the same concerns. These concerns reflected the lack of information about HIV/AIDS, scarce or negligible resources available for prevention or care, and the serious breeches of professional ethics and confidentiality in their care. They spoke of feeling scared, isolated, and alone. They hide their status and disease even from close relatives and providers although they are now involved in advocacy and prevention and are empowered by NGO efforts and support.

Monitoring and Supervision of Service Delivery

Although each clinic provides the regional and national level with a monthly report that presents information about the level of utilization, it does not allow monitoring of implementation (adequacy of supplies, performance of service providers) by comparing actual progress to expenditures. Instead, this process focuses only on information about patterns in the frequency and distribution of diseases. Design and implementation of such a system and the use of key indicators for monitoring the progress of the activities is urgently needed.

A supervision system to enable health providers to provide comments and suggestions, discuss problems, and receive support has not been appropriately implemented. There is a supervision guide that has been used for the past five years that needs to be updated. The supervision team visits the field only when funds provided by donors are available.

BEHAVIOR CHANGE INTERVENTIONS

Behavior Change Communication among High-Risk Behavior Groups

Behavior change communication (BCC) for HIV/AIDS–prevention programs has been challenged to refine traditional communication approaches to address usually private and sensitive matters, such as sex, trust, and death. BCC specialists working in HIV/AIDS have also begun to broaden their approach to address the social, political, and environmental factors that influence risk behavior. Experience with HIV/AIDS has made it clear that an individual can rarely sustain a change in behavior without a supportive environment.

Several NGOs in Nicaragua have implemented BCC interventions, especially for female sex workers and MSM. However, the quality of the design of the interventions and the IEC materials produced could not be evaluated. Furthermore, it was clear that a monitoring and evaluation program was lacking.

Technical assistance is needed to carefully plan, execute, and evaluate BCC strategies. Target audiences should be MSM and female sex worker communities. Research is needed to identify ways to communicate with those who are socially marginalized, including migrant workers, refugees, and those who are homeless and may be living on the street. Highly mobile populations pose special challenges for BCC campaigns because it is particularly difficult to continue reaching them with consistent messages as they move from place to place.

Sex Education and Behavior Change Communication Targeted to Adolescents

Sexual health education for children and young adults is one of the most highly debated and emotional issues facing policymakers, national AIDS program planners, and educators today. Arguments have raged over how explicit education material should be, how much there should be, how often it should be given, and at what age education should be initiated. Indeed, the question has been asked, "Why educate adolescents about sex, sexual health, and sexually transmissible diseases at all?" However, little evidence was found to support the contention that sexual health and HIV education promote promiscuity.

Nicaragua urgently needs a sexual education program for adolescents to achieve long-term goals in HIV prevention. Technical assistance should be provided to design a high-quality program and to assist in negotiations with high-level politicians and the Catholic Church.

Future educational programs need to incorporate the features that have been associated with successful interventions in the past, as well as mechanisms by which their impact can be evaluated. Program evaluation should be based on solid study design and valid and appropriate evaluation statistical techniques. Gender and the developmental stage of

students are issues for the educator and research at both the design and the evaluation stages of sexual health/HIV education development.

Influences on young people's sexual lives are not restricted to explicit messages about sex. In pursuit of an appropriate and effective way to promote healthy, positive sexual behavior, engagement with those influences is vital. It is important that policymakers, program managers, and teachers be aware that the evidence indicates that safer sexual practice among young people may be achieved through education. Failing to provide appropriate and timely information and services to young people for fear of condoning and encouraging sexual activity is not a viable option.

Condom Social Marketing

Once infected, there is no cure for HIV/AIDS, and the expensive and difficult drug therapies that are available are beyond the reach of virtually all persons infected in less developed regions. The only realistic response is to prevent HIV transmission through prompt diagnosis and treatment of STIs and behavior change, including the correct and consistent use of condoms by individuals at risk of infection. However, for a condom-based prevention program to have a significant impact on HIV incidence, there must be demand for the product, a sufficient supply of accessible and affordable condoms, the will to use condoms, the knowledge to use them correctly, and adequate communication mechanisms to provide information and encourage behavior change.

Demand for Condoms

Nicaragua does not have a condom use culture. According to the 1998 Demographic and Health Survey (DHS), only 3 percent of Nicaraguan women in union and 1 percent of women not in union but sexually active use condoms for family planning. In addition, only 1.6 percent of sexually active men reported using condoms occasionally. A search for data on this point may indicate different rates of condom use by different segments of the population, and perhaps trend data indicating changes in use levels over time, perhaps among young people or MSM.

Supply of Condoms

In assessing the supply, accessibility, and affordability of condoms at the time of day and in the locations where persons at risk of HIV need them, the total condom supply market should be investigated, including both the public and private sectors.

Preliminary data from Population Services International (PSI) indicate that there are approximately 3.8 million condoms sold and/or distributed in Nicaragua per year and that there is a range in choice and price, from the high end (Durex, at $0.48 each) to free

condoms from the MINSA. Whether this supply is sufficient or whether it should be increased to respond to unmet demand for condoms for HIV/AIDS/STI prevention or for family planning should be investigated.

Preliminary estimates from PSI (see the table on the following page) indicate that the nonsubsidized private sector provided 650,000 condoms in 1999, at prices ranging from $0.48 to $0.16 each. A small number of pharmaceutical distributors now import all current commercial condom brands and supply approximately 1,200 pharmacies nationwide. This two-level distribution structure is efficient and adequate to supply all wholesale distributors and retail pharmacies, each of whom marks up the price by 30 percent, the generally accepted mark up for similar products. PSI reports that USAID subsidizes the sale of 1,007,822 condoms per year through the VIVE regional program and the USAID Mission provides an additional 50,000 condoms per year to PROFAMILIA and the public sector family planning clinics. PSI also reports that the government of Nicaragua distributes an additional 2.1 million donor-funded condoms without identifying the donor source.

Estimated Nicaragua 1999 Condom Market Size and Shares

Brand	Unit Price	Annual Sales	Market Share (Private Sector)	Market Share (Total Market)
Durex	$ .48	250,000	15.0%	6.7%
Trojan	$ .40	100,000	6.0%	2.7%
Preventer	$ .16	150,000	9.0%	4.0%
Wild Cat	$ .16	50,000	3.0%	1.3%
Sultan	$ .16	100,000	6.0%	2.7%
PASMO/VIVE	$ .10	957,822	57.7%	25.5%
USAID No Logo to PROFAMILIA for family planning	$ .08	50,000	3.0%	1.3%
Public Sector (donor funded)	$ .00	2,100,000	0.0%	55.9%
TOTAL			n = 1,657,822	n = 3,757,822

Source: Population Services International

Note: USAID central procurement data record the following condom shipments to Nicaragua: 1997: 1.686 million, 1998: 3.582 million, and 1999: 3.492 million. These condoms were probably provided to MINSA and PROFAMILIA, but this should be confirmed. It is not clear if the 3.492 million condoms shipped by USAID in 1999 are included in the "Public Sector" line in the above table. By contrast, PROFAMILIA reports that 5.6 million condoms overall were imported into Nicaragua in 1999, of which 4.9 million went to MINSA and the balance went to the private sector, including PROFAMILIA and the PASMO VIVE program. These data should be carefully reviewed and reconciled and a profile prepared of the total condom supply in Nicaragua.

Condom accessibility needs to be investigated and described, especially for persons at risk of HIV/AIDS and in high-risk places, such as transportation routes, truck stops, and seaports. A 1999 PSI market survey reports that condoms are sold in 96 percent of pharmacies, 18 percent of supermarkets, 41 percent of gasoline stations, 22 percent of brothels, and 17

percent of motels. However, condoms are sold in fewer than 4 percent of bars and convenience stores and less than 8 percent of night clubs. According to the 1998 DHS, only 3 percent of women who had stopped using condoms for family planning reported accessibility as a reason.

No data were available on the affordability of condoms or the effective demand for this product among different populations at risk of HIV/AIDS in different parts of Nicaragua, especially among clients in high-risk locations. This topic should be investigated.

USAID Response

USAID currently supports two condom social marketing programs in Nicaragua selling USAID–subsidized competing branded condoms and, at least in part, targeting the same youth mass market. The PASMO Central American regional HIV/AIDS program, funded by the USAID Regional Program and managed out of Guatemala, sells VIVE condoms for HIV/AIDS prevention to high-risk groups and youth and to prevent unwanted pregnancy. The USAID/Nicaragua–funded DIMECOSA division of PROFAMILIA sells Bodyguard condoms primarily for the prevention of unwanted pregnancy among youth and heterosexual adults and secondarily for STI prevention.

The USAID Central American regional condom social marketing program, PASMO, sells the VIVE condom in Nicaragua. VIVE condom sales in Nicaragua have increased from 300,000 in 1998 to 1.3 million in 1999 and are projected to reach 3.3 million in 2000. VIVE currently has the largest share of the nonpublic condom market. VIVE is sold as a youthful and modern image product but has recently been repositioned from the "good times condom" to a product for sexually active adolescents, primarily to prevent HIV/AIDS and STIs and secondarily to avoid unwanted pregnancy. In addition to its mass-media branded product (VIVE condom) advertising targeting the youth market, PASMO has also recently been expanding its focus on high-risk groups (male adolescents, sex workers, MSM, and long-distance truck drivers). Although current VIVE condom sales are good, PASMO has been having difficulty expanding sales through commercial partners because there is little interest in a low-priced condom from potential distributors. PASMO is therefore seeking to expand sales in nontraditional outlets and through NGOs working with high-risk groups in high-risk zones. PASMO now has three salesmen who are responsible for meeting monthly nontraditional sales point objectives; PSI data show that approximately 30 percent of current VIVE sales are through NGOs, 18 percent through nontraditional outlets, and 52 percent through traditional channels. PASMO is now working with 13 different NGOs targeting different populations and different high-risk zones or geographic areas, which sell VIVE condoms and provide demonstrations of correct condom use and educational activities concerning HIV/AIDS. PASMO's media approach includes television advertisements for VIVE condoms targeting youth; generic television spots that will address unwanted pregnancy, STIs, and AIDS; and, radio spots to reinforce those messages.

PROFAMILIA (Nicaraguan Family Planning Affiliate)

PROFAMILIA has received a USAID/Nicaragua grant for a reproductive health social marketing program and plans to launch the Bodyguard condom brand in March 2000. The goal is to sell 1.6 million condoms in 2000 and 10 million over the three-year project. An extensive sales network includes the 11 PROFAMILIA clinics, commercial distribution to 1,600 pharmacies, distribution to 13 categories of nontraditional outlets by PROFAMILIA motorcycle salesmen based in the 11 PROFAMILIA clinics, and community-based distribution (CBD) by 1,200 CBD agents servicing communities surrounding the 11 PROFAMILIA clinics. The PROFAMILIA program will also reach 5,800 youth aged 15–24 through 12 youth clubs that each have 50 promoters/peer educators.

Bodyguard condoms will sell for US $0.08 each, which is $0.02 less than VIVE condoms. With USAID providing 10 million subsidized condoms along with funds for management and institutional support, packaging, and advertising, the Bodyguard campaign is expected to generate $500,000 in revenue over the three-year project. The PROFAMILIA social marketing program is expected to earn an additional $500,000 in the same time frame from the sale of USAID–donated oral and injectable contraceptives. The goal is that the nearly $1 million in projected income will provide an endowment to PROFAMILIA that will ensure program sustainability.

PROFAMILIA will accept and provide services to persons at risk of HIV/AIDS in their clinics but will not market or reach out to them. In addition to youth-oriented radio and television advertising of the Bodyguard condom, PROFAMILIA will air generic spots on the risk of pregnancy, condom use without shame, and AIDS awareness to combat the belief among 40 percent of Nicaraguans that AIDS is curable.

IV. IDENTIFIED RESOURCES

NONGOVERNMENTAL AND COMMUNITY-BASED ORGANIZATIONS

The NGOs contacted during this assessment were either suggested by the PASCA country representative or the Mission, or were known by the team as agencies and individuals relevant to informing the objectives of the assessment. Some interviews were scheduled during the fieldwork based on the suggestions of key informants and interviewees. It was not possible, however, to interview all of even the most relevant resources. It was also not possible to travel outside of Managua; therefore, the only non-Managua-based agencies contacted were those who had representatives attending meetings in Managua during the visit, such as the representatives from two NGOs in Bluefields. However, a wide range of diverse groups was contacted, all having some current or potential role in HIV in the country. (The interview summaries are available in appendix D.)

The situation regarding nongovernmental and community-based organizations in the country is unique and complex. It affords an HIV prevention and care initiative with enormous resources and challenges simultaneously. Nicaragua has hundreds of NGOs, many existing before the revolution, many formed during and after the revolution, and many formed during President Chamorro's government. Some have obtained legal status only in the past few years and were created to respond to outside resources and funding opportunities as well as local needs. Others have existed in some form or other even as administrations and policies changed. Some are funded principally by large international donors and may have offices in other countries as well, while others rely upon religious or special interest funding. Some have only local activities while others operate in different parts of the country. They range in focus from almost entirely HIV/AIDS–related, to having only a small role in research or prevention with specific target populations.

Most contacted had some political/partisan affiliation. One of the greatest challenges identified, in fact, is precisely the partisan nature of many NGOs that serve as a community base for individuals currently involved in the political process. Some NGOs are headed by individuals who were major political figures in other administrations and retain power within their own parties and groups. This situation is one of the greater challenges for a transparent process of funding and collaboration since it may place HIV–related policies, programs, and activities in the political arena (as witnessed with the presentation of the strategic plan by different political factions). Another challenge facing an HIV initiative involving this NGO community is its fragmented nature, which is a result of not only competition for scarce funds and different objectives, but the partisan nature of many of the agencies and their leadership. Coalitions fostered by external funding rather than political agendas or common objectives are fraught with problems. In addition, the present administration is antagonistic

toward the NGO community and thus serves as an obstacle to government–NGO collaboration.

The extraordinary range and number of agencies, on the contrary, is an important resource for HIV–prevention planning. NGOs exist throughout the country; many have wide networks that can reach urban, rural, high-risk behavior, and general populations. Some already have had initial training in HIV; some provide support and technical assistance to important networks of promoters, communicators, and professionals concerned with STIs and HIV as well as maternal and child health (MCH) and reproductive health. If indeed a development approach is incorporated into the Mission's initiative, even nonhealth NGOs working in poverty, environment, and education can be involved in education, information, and services with support and training.

In addition to the number and range of NGOs, it is important to note the energy and commitment these agencies have as well as the skill and experience of many of the individuals involved in the NGO community. The team was shown impressive materials, training curricula, and research results, many of which were achieved with little or no funding. Professionals and community leaders involved in these efforts who donate time and work tirelessly to improve the quality of life of their communities were also interviewed, as well as NGO staff members who understand and know how to reach communities at risk. It is important to stress the infrastructural resources as well as the human resources that could be supported in campaigns, projects, programs, and activities across the country.

U. S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

USAID's Mission in Nicaragua in 1995 provided support for AIDSCAP to develop HIV/AIDS prevention programs, building the capacity of local institutions to implement HIV/AIDS control and prevention efforts and to establish the concept of self-vulnerability among segmented audiences. A strategy was developed based upon an initial qualitative study with high-risk behavior groups (Fundación Nimehuatzin). Implementation began with the funding of NGO activities to support legislation for the Law for the Promotion and Protection of Human Rights of Nicaraguans Facing AIDS.

In 1996, a seroprevalence study among high-risk behavior populations was carried out in collaboration with the MOH and the University of Washington. Also in 1996, the Mission added funding for field activities that were distributed among projects implemented by the MOH and seven NGOs: Casa de la Mujer (Rivas), Casa de la Mujer (Esteli), Centro de Asesorias y Servicios Mujer y Familia, CICUTEC, the Red Cross, Nimehuatzin, and Fundación Mejia Godoy. The activities funded supported HIV/AIDS mass media communication, STI/HIV awareness training and education, design and production of prevention materials, HIV prevention for housewives, Red Cross lifeguard volunteer education at beaches, condom education for the general public, education for migrating and

rural populations, and song and videotape production. Greater awareness through the mass media reached about 450,000 people. About 800 people were trained to deliver HIV/AIDS prevention messages.

Programa Accion SIDA de Centro America (PASCA)

PASCA works to promote regulation and legislative processes that support HIV/AIDS issues, including the development of national strategic plans. The project has produced manuals and materials addressing priority HIV/AIDS issues and has provided training to NGOs throughout the region. PASCA has set up HIV/AIDS information dissemination centers in several countries, including Nicaragua. PASCA also has established AccionSIDA, a community-based approach for organizing and mobilizing local leaders to address the epidemic. PASCA is currently reevaluating staffing in all countries, including Nicaragua, and will coordinate closely with the Mission on the profile of the type of technical assistance needed to complement bilateral support.

PASCA has produced the following manuals, based on experience in Central America:

- *Strategic Planning for NGOs*,
- *Cadena de Cambios: Behavior Change Model for Research and Design,* and
- *Sustainability: A Self-Applied Module for Looking at NGO Options for Sustainability with Case Studies.*

PASCA materials addressing priority HIV/AIDS issues include:

- Peer education programs developed with youth, taxi drivers, armed service men, and drug-using street children;
- Integration of HIV/AIDS prevention into communication programming for women, clinics serving victims of violence, and public community-based clinics combining integration with a peer education program and migrating populations; and,
- AccionSIDA: prevention programs for youth, armed service men, sex workers, women working in maquilas, and housewives and other vulnerable populations.

PASCA has also provided direct support to selected NGOs for institutional strengthening; leadership training on how to assess leadership needs and design and implement training sessions for regional leaders from all sectors, with particular emphasis on HIV–positive persons; technical assistance to strengthen NGO advocacy capabilities; and, direct resources

to assess and implement training sessions on specific technical needs identified, establish country and regional information centers and web sites, and implement AccionSIDA approaches to promote community-based prevention planning.

PASCA also conducts some operational research and is carrying out a multisite surveillance study that will complement other regional studies (PASMO, 1998 and others) with populations of MSM and female sex workers in capital and port cities. PASCA's future plans include supporting efforts with mobile populations, probably through using AccionSIDA approaches or technical assistance through existing PASCA networks. Finally, PASCA will continue efforts to facilitate high-level policy dialogue with other partners at the regional level and between northern and southern institutions.

Pan-American Social Marketing Organization (PASMO)

The PASMO Central American regional HIV/AIDS program, also funded by the USAID Regional Program and managed out of Guatemala, sells VIVE condoms for HIV/AIDS prevention to high-risk groups and youth and to prevent unwanted pregnancy. As described above, PASMO's objective calls for selling low-cost condoms to low-income populations, targeting adolescents, sex workers, MSM, truck drivers, military personnel, and prisoners. Sales of VIVE condoms occur through drug stores in urban areas and through PROFAMILIA in rural areas. PASMO also has agreements with 13 Nicaraguan NGOs to reach different populations and vulnerable groups. These NGOs sell VIVE condoms and provide demonstrations of correct condom use and educational activities concerning HIV/AIDS. VIVE sells an average of 180,000 condoms monthly in Nicaragua, an increase of sales from 300,000 in 1998 to 1.3 million in 1999. VIVE's year 2000 goal is 3.3 million sales. NGOs account for 30 percent of PASMO's sales in Nicaragua, 18 percent through nontraditional posts, and 52 percent through traditional channels. Over the next four extension years, PASMO wants to increase condom distribution channels, geographic coverage of target populations through interpersonal IEC campaigns, and awareness about consistent condom use.

OTHER INTERNATIONAL SUPPORT

Norway (NORAD)

The Norwegian Embassy health advisor reported that NORAD has supported STI/HIV/AIDS prevention activities of national NGOs for a total of $1 million since 1995. This year, the Embassy signed a three-year contract with five NGOs to carry out interventions in sexual and reproductive health and community-level STI training: Xochiquetzal; Health Information, Services and Advisory Center (CISAS); Si Mujer; Centro Mujer y Familia; and, CEPS. Priorities identified for this second phase include developing a baseline to evaluate impact at the end of the project, strengthening care in reproductive health and HIV prevention,

purchasing reactive materials and medicines for STIs, and community training. Additionally, the Embassy has funded a $750,000 three-year PAHO initiative focused on linking efforts of other international agencies and NGOs working in HIV/AIDS prevention to stimulate intersectoral coordination and promote social communication. The program includes educational interventions in border areas with mobile groups, specifically in the departments of Chinandega, Nueva Segovia, and the Atlantic Coast.

Pan American Health Organization (PAHO)

PAHO has initiated discussions with donors, the United Nations, the Ministry of Health, and NGOs on HIV/AIDS issues. PAHO's new director in Nicaragua came to the country with 20 years of experience in African countries heavily affected by AIDS and has said that "the epidemic trend is reliable and alarming," noting that "there is not only one epidemic in the country, there are several, and the only advantage Nicaraguans have is time." Some priorities mentioned for intervention include training for health personnel, condom promotion together with an aggressive education campaign, diagnosis teams stationed in sentinel sites, the development of social communication strategies, support for hospital biosafety and serological tests, and studies that optimize and strengthen available resources. He also observed that "there is a false reliability in unsolid figures," referring to the low number of confirmed AIDS cases and the lack of information that suggests the epidemic in Nicaragua has low priority. A PAHO official reported that PAHO's $750,000 agreement with the Norwegian government will also support laboratories and strengthen epidemiological surveillance and prevention activities.

V. PROPOSED STRATEGIC FRAMEWORK

APPLYING WORLDWIDE EXPERIENCE TO NICARAGUA

Human Ecology and Behavior

The three direct determinants of the rate of spread of STIs are sexual practices, the mean duration of infectiousness, and the mean efficiency of sexual transmission of each STI. Underlying ecological and behavioral factors that operate through one or more of these direct determinants are on a continuum, ranging from those most proximate back to those more remote (in time or mechanism) from the direct determinants. Most remote and least modifiable are the historical stages of economic development that even today conspicuously influence patterns of sexual behavior. Next are the distribution and changing patterns of climate, hygiene, and population density; the global population explosion and stages of the demographic transition; and, ongoing changes in human physiology (e.g., menarche at a younger age) and culture (e.g., later marriage). More proximate on the continuum are war, migration, travel, and current policies for economic development and social welfare. Most recent or modifiable are technological and commercial product development (e.g., oral contraceptive), circumcision, condom use, spermicides, and contraception practices; patterns of illicit drug use that influence sexual behaviors; and, the accessibility, quality, and use of STI health care. These underlying factors help explain why curable bacterial STIs are epidemic in developing countries.

Act as Soon as Possible

There are several reasons why early intervention to change high-risk behavior is preferable to later action. Early in an epidemic, HIV spreads exponentially. Because few people are infected, the probability is low that unprotected sex involving an infected person and a random partner will result in a new infection. However, since few people are infected, a prevention campaign focusing on the high-risk behavior and vulnerable populations can significantly reduce the transmission rate among members of these subgroups and ultimately, to members of the general population. Also, interventions cannot be put in place instantly, requiring a period of trial and error to discover which approach works best in a particular setting. Finally, it is far less costly to prevent HIV infections than to treat people with AIDS.

The Multiplier Effect of Changing the Highest Risk Behavior

The HIV epidemic is largely influenced by the amount of mixing between people with different practices of risky behavior. Preventing HIV infection in someone with a high rate of partner change will indirectly avert many more future infections than preventing an

infection in a person who practices low-risk behavior, has few partners, and therefore is less likely to infect others.

A simple calculation illustrates the power of reducing STI or HIV transmission among those with the highest rates of partner change. If gonorrhea screening and treatment is provided to 500 female sex workers, 25 percent of whom have an STI, and if each sex worker has an average of four partners a day and the probability of transmitting STIs to male clients through vaginal intercourse is 30 percent, then this program would avert 165 new gonorrhea cases per day among these clients. It would, of course, also avert many secondary infections of other partners of these clients, including their wives.

Cost-Effective Interventions

Few HIV interventions have been rigorously evaluated with respect to their impact on the incidence and prevalence of HIV; among those evaluated, interventions targeted to those who practice high-risk behavior have been proven to be more effective than others. The effectiveness of alternative interventions will be strongly influenced by the nature of the intervention itself and by the heterogeneity of the behavior that is fueling the epidemic. In van Vliet et al. (1999), the impact of increased condom use and increased treatment of curable STIs on a heterosexual HIV epidemic was simulated. The authors concluded that although the overall pattern of sexual behavior in the population does affect the impact of interventions, prevention of infection among those with the highest rates of partner change has the largest effect. Also, increasing rates of condom use among those with high rates of partner change as well as focusing condom subsidies and promotion efforts on changing the behavior of these groups is likely to be highly cost-effective. Thus, interventions should have the greatest impact if they are effectively focused and delivered among individuals who have many partners and in dense sexual networks.

Prevention of HIV Sexual Transmission

Global strategies to prevent the sexual transmission of HIV have focused on three primary approaches: increasing access to and demand for condoms, mainly through condom social marketing programs; reducing sexual risk through behavior change communication (BCC); and, treating and controlling STIs.

STIs have long been implicated as a cofactor for HIV transmission and are a major public health problem in most developing countries. Studies in both industrial and developing countries have found that people with current or past STIs are 2–9 times more likely to be infected with HIV. Subsequent studies have shown that urethral and endocervical lesions caused by nonulcerative STIs increases genital shedding of HIV−infected cells, and thus increases infectivity of the person with HIV infection.

The rate of spread of STIs, including HIV, is determined by three factors: the average rate of exposure of susceptible persons to infected persons, the average probability that an exposed susceptible person will acquire the infection, and the average time that newly infected persons remain infectious and able to continue spreading infection. Thus, interventions can prevent the spread of an STI within a population by lowering the rate of partner change, reducing the efficiency of transmission, or shortening the duration of infectiousness of that STI.

From the above information, it is clear that the distinction between behavioral and biomedical interventions for STI prevention is artificial, since both behavioral and biomedical approaches are often required, whether the objective is preventing exposure, preventing acquisition, or preventing transmission of STIs. In fact, behavioral and biomedical approaches are complementary and interdisciplinary approaches are essential. Biomedical interventions are ineffective without behavioral components to support them and behavioral approaches must address all of the factors responsible for sustaining transmission of infection.

Service Delivery and STI Control for High-Risk Populations

The provision of accessible, acceptable, and effective care services is a cornerstone of any program for the control of STIs. In Mwanza, Tanzania, a randomized trial to evaluate the impact of improved STI case management using syndromic management at the primary health care level demonstrated an HIV cumulative incidence over two years of 1.2 percent in the intervention community, compared with 1.9 percent in the comparison group—a 40 percent reduction. This study demonstrated that STI treatment is an important prevention strategy in HIV infection for the general population. However, this strategy addresses STI care for symptomatic STI patients at the primary health care level. For asymptomatic STI patients with low or high-risk behaviors, a different approach is necessary.

STI clinics in urban settings are useful in providing primary care for specific groups, such as sex workers and their clients, migrant workers, truckers, and any other group with poor access to health care. Also, because of a concentration of STI expertise, these clinics can offer referral services for primary care clinics, hospital outpatient clinics, private practitioners, etc. These clinics should also be strengthened by providing their personnel with training in STIs and with epidemiological information (e.g., prevalence of etiologic agents within syndromes and antimicrobial susceptibility) and operational research (e.g., studies on the feasibility and validity of algorithmic approaches).

Few studies have shown that effective diagnosis and treatment of STIs have influenced the prevalence and incidence of STI/HIV among female sex workers. In 1994, through Project SIDA in the Democratic Republic of Congo (formerly Zaire), Laga reported success in

reducing HIV incidence among female sex workers through condom promotion and STI treatment.

Few countries in Latin America have established an effective STI diagnosis and treatment program for female sex workers. Sanchez et al. in Peru have evaluated a limited periodic examination program, concluding that the scope, quality, and efficacy of STI control programs must be technically appropriate, well managed, and adequately financed, and that the safety of marginal programs warrants scrutiny. The same team proposed and implemented a model for STI care that includes

- initial ethnographic research on health-seeking behavior and perceived needs,
- modification of STI services configuration to meet perceived needs and reduce perceived barriers,
- communication and counseling on risk reduction,
- social support or easy access to related social services,
- motivation to seek care for new signs or symptoms,
- regular periodic examination for symptoms or signs of STIs and appropriate treatment,
- monitoring the prevalence and incidence of STIs to guide the frequency of testing,
- examination of cost-recovery practices and actual allocation of funds recovered to the services provided,
- extension of services to female sex workers not traditionally served by existing programs,
- consideration of anonymous or confidential HIV serology, and
- evaluation of the acceptability and effectiveness of the program.

Peer Education Strategy

Current literature suggests that peer education is a widely used component of HIV–prevention programs across population groups and geographic areas. The literature also indicates that peer education is seldom implemented alone. Rather, it is often part of a larger

and more comprehensive approach to HIV prevention that includes condom distribution, STI management, counseling, drama, and/or advocacy.

Review of some of the studies that have evaluated HIV/AIDS peer education programs using experimental or quasi-experimental designs, with outcome indicators such as reduction of HIV−related risk behavior and/or STI/HIV incidence, shows that peer education (in combination with other prevention strategies) is very effective in several populations and geographic areas. However, researchers and program planners are still faced with the task of determining the critical elements of peer education within the context of a comprehensive HIV−prevention strategy that will reduce HIV risk behavior and incidence in a given population and context.

GLOBAL USAID RESPONSE TO HIV/AIDS

USAID has undertaken a comprehensive review of its strategy to respond to the HIV/AIDS pandemic. The Agency's new Strategic Support Objective is to "increase the use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic." This objective was built on two overriding themes: the need for continued and expanded emphasis on sustainable responses to prevent HIV transmission, and a new emphasis on mitigating the epidemic's impact on individuals and communities, while more closely studying its social, economic, and policy impacts.
USAID will use six approaches to achieve this objective:

- strategies to reduce the sexual transmission of HIV;
- managing and preventing STIs;
- eliminating barriers to providing HIV/AIDS services to youth, women, persons living with HIV and AIDS, and other vulnerable populations;
- increasing the capacity of nongovernmental, community-based, and commercial organizations to respond to HIV/AIDS;
- increasing the quality, availability, and use of evaluative and surveillance information; and,
- developing and promoting effective strategies for providing basic care and support services for people living with HIV and AIDS.

Programs should incorporate the following crosscutting issues into design, implementation, and evaluation of their activities: gender, sustainability, community ownership, contextual change, youth, and local capacity.

VI. RECOMMENDED STRATEGY

OVERALL STRATEGY

Implications of worldwide lessons learned for the new USAID/Nicaragua bilateral program design are clear.

1. An integrated, multidisciplinary, multisectoral and multilevel (national, provincial, and community levels) approach appears to be the best approach. It is increasingly clear that the multifaceted determinants and impacts of HIV/AIDS cannot be managed by the health sector alone. **New emphasis on risk situations has made it clear that sustainable programs for HIV/AIDS prevention, care, and support should be conceptualized within a broad development framework**. Poverty, political disenfranchisement, gender discrimination, and lack of political will both impede successful interventions and reinforce risk-producing situations. Successful intersectoral efforts require a broad coalition among governmental and nongovernmental agencies, men and women, adults and young, and service providers.

2. Individuals with multiple sexual partners are particularly vulnerable to acquiring STIs and thereafter transmitting infection to additional sexual partners. The members of such core groups are likely to play a significant role in the maintenance of high rates of STIs and it is expedient to target STI services and prevention activities to them.

3. Comprehensive approaches are more effective than isolated interventions. Strategies for preventing sexual transmission of HIV should include increasing access to and demand for condoms, mainly through condom social marketing programs; reducing sexual risk through behavior change communication (BCC); and, treating and controlling STIs.

4. The design, implementation, and evaluation of HIV/AIDS intervention activities should apply crosscutting issues, such as human rights, gender, youth, community ownership, sustainability, and local capacity building.

Policy Strengthening

The overarching environment in which the stakeholders in HIV prevention in Nicaragua work should be more receptive and committed to HIV/AIDS activities than it is currently. In the public sector, the Nicaraguan government's commitment to HIV/AIDS prevention should increased. In the private sector, business and industry should be aware of the HIV/AIDS situation and its possible implication in Nicaragua and should be sensitive to the needs of those infected. Activities in HIV/AIDS prevention, care, and support need to be

more closely coordinated within the overarching environment, resulting in additional and improved prevention actions and services.

1. A targeted policy dialogue strategy should be designed to disseminate the law, regulation, and national strategic plan to multisectoral audiences, including business, the human rights sector, the women's sector, PLWHAs, the media, and other programs.

2. An advocacy agenda needs to be established and a strategy developed, in particular for PLWHAs.

3. USAID/Nicaragua should take an active role in the revision of the national strategic plan.

4. USAID/Nicaragua needs to take an active role in donor coordination.

Data Collection

1. The HIV case reporting system and data management needs to be improved. The AIDS case definition needs to be revised and a computerized system based on the new case reports for each region needs to be implemented. As a consequence of the success of this implementation and an increase in HIV testing, better HIV/AIDS projections will be available.

2. An effective and efficient system of STI/HIV surveillance needs to be designed and implemented. The overall aim of such a system is to provide data to guide and target intervention activities. Specific objectives of such a system are to measure the current level of infection in the population; to identify variation by age, sex, and risk factors; to monitor the progress of the epidemic; and, to measure trends in prevalence or incidence by age and sex. At early stages of the HIV epidemic, it is most important to monitor for infection among subgroups of the population most at risk. For Nicaragua, this might include female sex workers, MSM, and STI patients.

3. The implemented surveillance needs to be integrated with the regional surveillance system proposed by PASCA to allow more accurate characterization of the epidemic due to the migration patterns in the region.

4. Future outputs of the USAID/Nicaragua bilateral program should include operational research in areas such as

    - STI services: validation of the current flow charts for syndromic management and assessment of the quality, availability, and demand for STI prevention and management services; and,

- Behavioral research: refinement and evaluation of tools for identifying risk behaviors, sexual networks, epidemiological bridges between population, migration, and health-seeking behaviors of high-risk behaviors and vulnerable populations targeted by the program.

Diagnosis and Treatment of Sexually Transmitted Infections

1. Promote accessible, acceptable, and effective case management of persons with STIs through public and private health care systems, including primary level health care, using syndromic management. Activities under this strategy should include revision of the national guidelines, training of health care providers, availability of the means for consultation and examination, consistent availability of appropriate drugs, consistent supplies of condoms, avoidance of constraints in acceptability of services, promotion of appropriate health-seeking behavior, and establishment of an adequate monitoring, supervision, and evaluation system.

2. Target acceptable and effective STI care services to populations identified as being particularly vulnerable to infection with STIs, including HIV (i.e., female sex workers and their clients, MSM, mobile populations, and ethnic minorities).

3. Strengthen the diagnostic capability in laboratories and identification of STI reference centers. This would allow training of health workers and laboratory personnel, an epidemiological and microbiological survey, antimicrobial susceptibility monitoring, validation of the flow chart, sentinel surveillance, and diagnostic confirmation of selective cases at referral centers.

4. Establish a system of counseling services with or without STI/HIV testing tailored to the needs of particular client groups, some of which have very different needs.

Behavior Change in High-Risk Behavior Groups and Adolescents

1. Provide technical assistance, financial resources and training to design, implement, monitor, supervise, and evaluate a BCC intervention that complements condom promotion and STI diagnosis and treatment for MSM, female sex workers, and mobile populations concentrated in geographic areas where the program will be developed.

2. Provide technical assistance to design a high-quality program for adolescents that is based on social learning theory; has focused curricula, giving clear statements about behavioral aims, and features clear delineation of the risk of unprotected sex and methods to avoid it; focuses on activities that address social influences; teaches and allows for practice in communication and negotiation skills; encourages openness in communicating about sex; and, equips youth with skills for decoding media messages

and their underlying assumptions and ideologies. In addition, technical assistance should assist in negotiation with the political sector and the Catholic Church.

Condom Social Marketing

USAID/Nicaragua already has backed into a condom strategy defined by the two large condom social marketing programs it supports. Therefore, a consultant should be hired to complete a total condom market assessment to

1. Provide information to help the Mission guide, monitor and evaluate, adjust as needed, and coordinate the two programs to assure maximum results. This assessment (in order to complement the data provided by Dr. Heisler), should investigate, review, and discuss

   - demand for condoms and search for data that may indicate different rates of condom use by different segments of the population, as well as any trend data indicating changes in use levels over time, perhaps among youth or MSM;

   - whether the condom supply is sufficient or if it should be increased to respond to unmet demand for condoms for HIV/AIDS/STI prevention or family planning;

   - the affordability of condoms or the effective demand for this product among different populations at risk of HIV/AIDS in different parts of Nicaragua, especially among clients in high-risk locations;

   - risk behaviors, knowledge of AIDS, and condom use: sexual behaviors among youth (both in and out of school), rural and urban differences, and high-risk groups and locations (men in uniform, migrants/truck stops, migrant labor situations, seaports, jails, etc). Distinguish between commercial and transactional sex behaviors among sex workers and MSM. Finally, this section should pay attention to crossover behaviors from high-risk groups to the general population and note the danger of unprotected anal sex;

   - communication options: it is important to know the availability, cost, and coverage of radio, television, newspapers, and magazines throughout the country. It is equally important to know the proportion of persons who have access and listen to radios and televisions, and those who can read and who purchase newspapers and magazines, especially because of the issue of access to members of high-risk groups who may be outside the general population or difficult to reach because they may not identify themselves as a member of a high-risk group (e.g., MSM);

- social and institutional constraints: the impact of institutional constraints on an HIV/AIDS–prevention program based on the correct and consistent use of condoms, for example, the willingness of the mass media to transmit frank and explicit advertisements and information about condom use should be discussed. The paper should also discuss the social constraints that affect how different population groups obtain information about sexuality, STIs, and HIV/AIDS, for example, under what conditions men and women, parents and children, teachers and students, can discuss these issues; and,

- condom distribution programs and HIV/AIDS–prevention programs of other donors and the government of Nicaragua.

2. Help in coordinating the two CSM programs, PASMO and PROFAMILIA, perhaps formally through parallel work plans; ensure synergy in their advertising and IEC campaigns. The combined impact of the two programs should be monitored to document the increase in condom accessibility and affordability, expansion of the total condom market, increase in consistent and correct use of condoms, creation of condom awareness, and behavior change regarding condom use, especially among high-risk behavior groups and youth in Nicaragua. The Mission should provide clear written guidance to both PASMO and PROFAMILIA on the reporting and communication products needed. A combined program monitoring and evaluation plan should be prepared and agreed to by all parties, and regular program implementation and review meetings should be scheduled.

STRUCTURE OF THE PROGRAM TO BE SUPPORTED BY BILATERAL FUNDS

The overall goal for the new bilateral funds of USAID/Nicaragua should be to increase the use of HIV/AIDS information and other services in Nicaragua. Both key decision-makers and the general population need to understand HIV/AIDS in Nicaragua better and, through that understanding, **support ethical, quality activities in prevention, care, and support.** Mounting technically sound, cost-effective activities will be greatly facilitated by strengthening the institutional partners in HIV/AIDS, increasing the visible governmental support for HIV/AIDS services, and improving coordination of activities.

The major stakeholders in HIV/AIDS prevention should be strengthened. In the public sector, the National AIDS Control Program should be strengthened at both the central and regional levels. In the private sector, the participation of nongovernmental organizations in HIV/AIDS prevention, care, and support should be expanded and strengthened in terms of technical quality, management capability, and sustainability.

To achieve the above goal, the needs assessment team envisioned that activities should be implemented through three components. In addition, USAID/Nicaragua should play an

important and direct role in the policy dialogue previously suggested. The three components are:

1. **Strengthen the government response:** Technical assistance, financial resources, training, monitoring, supervision, and evaluation will be needed in this component to develop or expand the following areas according to the strategies previously described: surveillance, diagnosis and treatment of STIs, HIV counseling and testing, laboratory strengthening, care and support of PLWHAs, and behavior change communication interventions among adolescents.

2. **Strengthen and expand the response of the NGOs:** Technical assistance and financial resources will be needed in this component to research, design, implement, and evaluate BCC interventions directed at high-risk behavior groups. In addition, NGOs should participate in policy development and advocacy, particularly related to HIV/AIDS and human rights. No more than two NGOs should be supported as a first step to serve as local sources of future program development.

3. **Small grants to support ongoing activities or implementation of short-term activities or interventions:** This suggestion results from the identification of specific and immediate needs during agency visits. Various ongoing efforts were reported to the team which were to be reduced or discontinued because of lack of funding as well as activities which, with a small amount of additional funding, could be expanded to cover a larger audience or new communities. Efforts were also identified for which some additional funding would permit the implementation of activities that were already designed or the production of materials necessary to support activities or disseminate information. These included the need for funds to continue ongoing radio spots, begin new spots, document topics addressed during radio programs for dissemination, cover the cost of an Internet connection for a documentation center, and obtain technical assistance for an ongoing, unfunded research effort by adolescent clinic staff on violence. Clearly, there are many more instances where such money could maximize efforts and where the provision of support would be highly cost effective with concrete short-term results.

   The application process would need to be straightforward and the decision-making procedures and criteria clear. A politically neutral mechanism with a transparent process would be crucial in the success of this component. If tied to other objectives or funding mechanisms, it could lose vital flexibility. A simple monitoring and evaluation component would provide documentation of the value of this component.

APPENDICES

APPENDIX A

SCOPE OF WORK

(from USAID)

AIDS NEEDS ASSESSMENT IN NICARAGUA

SCOPE OF WORK

Purpose: ***To assess the conditions of the HIV/AIDS epidemic in Nicaragua by exploring the availability, accessibility and utilization of HIV/AIDS services and interventions to prevent Sexually Transmitted Infections (STI) at the community, NGO and governmental levels.***

Background: Nicaragua faces a very serious health threat from the rapid spread of HIV/AIDS. Vulnerable groups, including prostitutes and clients of prostitutes, men who have sex with men, mobile groups (such as refugees and migrant workers), adolescents, street children, and prisoners are also at high risk. Nicaragua shows incidence of STIs alarmingly similar to patterns of early stage infection in other countries. Even though Nicaragua represents only 2.5% of all cases in Central America, with a rate of 5.5 cases per million inhabitants, the tendency is that by the end of this year there will be about 8,300 HIV cases diagnosed, according to the Nicaraguan Ministry of Health (MOH). It means that by the end of this year, we will have moved from a nascent epidemic to nearly a generalized problem.

The prevalence of STIs in Nicaragua has increased over the last 5 years, due to a rise in the number of gonorrhea cases (more than 4,000 cases/year). The effect of this increase has been particularly problematic for the rural areas of the country already affected by Mitch.

Among the population groups most vulnerable to STIs in Nicaragua, adolescents are at particular risk because of low condom use. The 1998 Demographic and Health Survey revealed that 47% of Nicaraguan women are mothers or pregnant by age 18. Only 11% of teens use modern methods of contraception and less than 1% of sexually-active 15-19 year old women use condoms. Condom use among commercial sex workers is also dangerous low.

The GON has recently approved an AIDS National Strategic Plan and Law 238 to protect the human rights of HIV patients. In this context, USAID/Nicaragua proposes launching a new bilateral prevention program to address the HIV/AIDS epidemic. To insure the most effective use of HIV/AIDS funds, the Mission will conduct a complete AIDS needs assessment, using technical expertise from Global, G/CAP Regional, and local AIDS prevention projects. The Mission will use the outcome of this assessment to design an effective program for USAID funds that will contribute to a national AIDS awareness campaign.

Scope: Through this proposed assessment, USAID/Nicaragua is interested in exploring options for strengthening policy dialogue, integrating mobile groups into HIV/AIDS interventions, and addressing the needs of new vulnerable settlements organized as a consequence of Mitch. The assessment will also examine the potential of the NGO community to make condoms more accessible to vulnerable or marginalized groups and focus STI interventions on youth, Mitch-affected populations, and ports. As with any other STI epidemic, we need to identify options to integrate the HIV prevention component more vigorously into reproductive health programs. Over the long term, we will seek to identify broader HIV risk reduction interventions that address the social development, human rights, and economic needs of populations at risk.

Analytical Tasks:

A. Community level

- Reproductive health and HIV/AIDS available services
- Type of community organization
- Community response
- Community self-management groups
- Capacity of health workers and promoters functioning at community level
- Access to contraceptive methods (condom distribution posts and costs)
- Access to RH/HIV/AIDS counseling services
- Coverage of educational interventions
- Interventions for mobile groups
- Differences in access, acceptability, and utilization of services by ethnic groups, geographic areas and vulnerable groups

B. NGO level

- Types of available and delivered services
- Services coverage
- NGO networks operational
- Role of each network, coverage and impact in civil society
- Activities carried out in policy dialogue
- Interventions for mobile or marginalized groups
- Strategies for condom marketing (limitations)
- Lessons learned
- Commitment to or interest in STI and HIV/AIDS interventions or adolescent development
- Staff skill level or experience in HIV/AIDS prevention work, infectious diseases surveillance, interventions related to adolescents, and health policy

C. MOH level

- Services designed for vulnerable groups
- RH/HIV/AIDS interventions and coordination with NGO's
- Specific interventions for adolescents, migrant populations, homosexual, street children, and prostitution (policies)
- Epidemiological Surveillance National System
- Common points between Strategic National Plan and USAID/N Priorities

Recommended Approach:

1. Review all documents, assessments and reports related to HIV/AIDS in Nicaragua (AIDS National Strategic Plan, Law 238, PASMO survey, etc.).
2. Meet with PVOs, local NGOs, major international organizations, other partners and key host government officials active in RH/HIV/AIDS activities in Nicaragua (OIM, MOH, PASCA, CONISIDA, Nimehuatzin, etc.).
3. Meet with MOH key personnel to learn about programs they have designed for vulnerable groups and to discuss coordination with NGOs and civil society.
4. Conduct field trips to critical geographic areas to see "in situ" HIV conditions.
5. Draft a report covering the items detailed in the above section on the scope of work.
6. Discuss findings with USAID/Nicaragua, MOH, partners, etc.

Final Report:

The draft of the final report should be ready after completion of the assessment. Final report should be submitted to USAID two weeks (?) after the assessment is done. The body of the report should not exceed 30 pages and should include an Executive Summary.

APPENDIX B

PERSONS AND INSTITUTIONS CONTACTED

APPENDIX B

PERSONS AND INSTITUTIONS CONTACTED

USAID
Marilyn Zak, Mission Director
Earle Lawrence, Health Development Officer
Katie McDonald, General Development Officer
Danielle Roziewski
Rodger Garner

AMNLAE
Lic. Dora Zeledon

ASAMBLEA NACIONAL, COMISIÓN DE SALUD
Rita Fletes

CAMPAÑA COSTEÑA
Ricardo Taylor

CENTRO MUJER Y FAMILIA
Xanti Suárez

CEPRESI
Norman Gutierrez

CEPS
Dr. Leonel Arguello
Esperanza Camacho

CIES
Alicia Pineda

CISAS/CEDOC
Lic. James Campbell

COMISIÓN NACIONAL DE LUCHA CONTRA EL SIDA
DESDE LA SOCIEDAD CIVIL
Dr. Leonel Arguello
Esperanza Camacho
Xiomara Luna
Marilyn Mora

CRUZ ROJA
Dr. Rene Berrios

DAMAS DIPLOMATICAS
Rosario Bernheim
Dr. Cordiva

DIMECOSA

FEDERACIÓN NICARAGÜENSE DE ONGS
Ana Quiróz

MINISTERIO DE SALUD
Dr. Amador, Director, Epidemiology
Dra. Matilde Román, Director, National AIDS Control Program
Hospital Berta Calderón, Adolescent Clinic

MINISTRY OF EDUCATION
Dr. Tablada, Vice Minister

MOVIMIENTO MULTIÉTNICO
Eloisa Hudson

NIMEHUATZIN
Rita Arauz

OIM
Ivan Dávalos
Beatríz de Briones

PASCA
Mercedes Tenorio

PASMO
Lic. Luis Fernando Martinez
Licda. Carolina Ramirez

RED DE COMUNICACIÓN
Licda. Mercedes Rivas

RED DE ETÍCA

RED POSITIVA
Sergio Navas

TESIS
Lic. Danilo Medrano

UNAIDS
Ninoska Salazar

UNDP
Monserrat

UNFPA

XOCHIQUETZAL
Hazel Fonseca
Diana Cordoba
Lesbia Gutierrez

KEY INDIVIDUALS
Dr. Guillermo Porras, Infectious Disease Specialist
Dr. Roberto Pao

APPENDIX C

INTERVIEW GUIDE

APPENDIX C

INTERVIEW GUIDE

GUIA PARA ENTREVISTA CON LAS ONGS

Nombre:
Dirección:
Teléfono:
Fax:
Email:
Tiempo de trabajo:
Percepción de la epidemía en el país:
Tiempo de trabajo en VIH/SIDA:
Staff:
Misión/Visión:
Objetivos:
Población Objetivo:
Programas/Proyectos:
Fuentes de financiamiento:
Relación con otras instituciones nacionales e internationales, política o programatica:
Percepciones/Problematica de sus poblaciones objetivo:
Intervenciones programadas o sugeridas a corto y mediano plazo por parte de su institución:
Visión nacional a corto y mediano plazo: ¿qué necesita hacer para responder adecuadamente a la epidemia?
Producen materiales (IEC):
Qué materiales educativos de otra fuente:
Han tenido asistencia técnica, areas de asistencia técnica:
Opinión de la asistencia técnica:
Información/datos para programación:
Opinión sobre estratregia para apoyar ONGs:
Opinión sobre integración de VIH/SIDA en problema de Desarrollo:
Opinión sobre el mensaje del uso del condón:
Cómo se puede reforzar la infraestructura para reforzar los servicios preventivos:
Hay coordinación entre las ONGs; entre las ONGs y el MINSA:
Logros nacionales en formulación de políticas:
Donde se deben enfocar los fondos (población, área geografica):
Opinión sobre la intervención en la población general en vez de subpoblaciones:
Cómo se puede involucrar al sector privado:
¿Se puede involucrar PLWHA en educación comunitaria? ¿En otras actividades?
Cómo ve al MINSA; qué tipo de apoyo requiere MINSA:

¿Cómo integrar actividades de prevencion del ETS/VIH a otros programas de prevención?
Opinión sobre campañas y educación masiva:
Opinión sobre medios masivos de comunicación:

GUIA PARA ENTREVISTA CON EL MINSA

¿Donde se encuentra al programa de ETS/SIDA en la estructura del MINSA?
¿Existe planes operativos anuales?
¿Cuál es la relación del plan operativo con el plan nacional?
¿Cuál es la fuente de financiamiento del PROCETSS?
¿Cómo es el registro de casos de VIH, anónimo, público vs privado, subregistro, retraso de la notificación?
¿Existe notificación de sindromes de ETS, cuál es el flujo de los servicios al nivel central?
Existe vigilancia centinela; qué poblaciones, qué lugares:
¿Qué indicadores de proceso y de impacto se han medido? ¿Existe DHS?
¿Hay servicios especializados para la atención de personas viviendo con VIH?
¿Hay servicios de ETS: especializados, integrados, tipo manejo, gratuidad, accesibilidad, aceptabilidad, calidad?
Servicios de tamizaje de VIH y consejeria: número, lugares, accesibilidad, aceptabilidad, control de calidad:
Integración de ETS en primer nivel: APN, PF, TBC:

APPENDIX D

INTERVIEW SUMMARIES

APPENDIX D

INTERVIEW SUMMARIES

MINSA

The team met with Dr. Juan Jose Amador, director general of environmental health and epidemiology, to discuss MINSA's perception and response to the epidemic. Dr. Amador had invited Dr. Mathilde Roman, director of HIV/AIDS, to attend. Dr. Amador explained that MINSA has had three HIV/AIDS directors and that HIV was "a great challenge." He stated that people believe that MINSA is lying with their statistics—that the government is hiding cases of HIV/AIDS. Two factors were given as important in keeping the statistics low: the commercialization of blood was against the law and much of the migration was outmigration because of wars and disasters. As an epidemiologist, he believes that epidemiology is an important part of their programs, "muy dentro los servicios," even as he recognizes the need for STI/HIV surveillance.

The epidemic was identified in Nicaragua in 1987–88, when Europeans with HIV were seen and repatriated persons were examined. "We have 400 cases, really people coming back to die or who are already sick." His priorities are prevention, information, and training, and the need for surveillance to establish HIV/AIDS prevalence. As obstacles to prevention, he cited the difficulties in working with schools, the Catholic Church, and other ministries. He would like to see MINSA in schools, but even the program of "Salud Escolar" has been blocked, and he would like to see more collaboration with NGOs. He also expressed concern that the "law says we have to give antiretrovirals; this year will be critical." Dr. Amador also addressed the problems of the MINSA infrastructure, saying that they do not even own the sites of many clinics and so cannot maintain or repair them.

He also stated that MINSA participated in the development of the law and regulation, but noted that outside funding played a role in the passage of the regulation with "contradictions" and "penalties." He said that the Assembly approved something with many sanctions and people should be motivated, not controlled, by sanctions. Regarding the strategic plan, he again cited outside influence that "says we need a plan." PASCA came with money, he noted, and said that we need a plan. "We didn't have time to think things through first." He went on to explain that the problem with PASCA was that they finance efforts "with a different rhythm," "all of a sudden there is an external dynamic and then a product" ("de repente una dinamica externa y sale un producto"). "Directing funding should not have been part of the plan," said Dr. Amador. He saw it as an action plan rather than a strategic plan. Dr. Roman noted that the strategic plan is flexible and that El Salvador revised its plan with technical assistance. She went on to say that NGOs see HIV monies as their resources and that NGOs must coordinate activities so as not to duplicate them so that activities can be

monitored. She noted that the monitoring plan has not been completed and was due in February.

Priorities for USAID support were said to be:

1. Case management: clinics are unable to treat cases, few clinics treat STIs, and discrimination sends people (sex workers and homosexuals) to NGOs who do not report cases;

2. Technical assistance to the Ministry of Education: prevention in schools;

3. Medicines for STIs;

4. Reagents for testing: MINSA gives limited reagents to clinics so that the epidemiologists control testing and decide who will get tested to maximize scarce reagents; and,

5. Attention to confidentiality in testing and services ("we know this is a big problem").

MINISTRY OF EDUCATION

A meeting was held with Dr. Tulio Tablada, vice minister of education (since replaced). Dr. Tablada was seriously concerned about the quality of education available as well as the number of youth outside the system and the number becoming pregnant. He was optimistic about a new model of education using television connected to a low earth orbit satellite, a technology permitting additional coverage and updated information to the children. Most of the discussion, however, was focused upon the obstacles to sex education and the influence of the church. Dr. Tablada believes that STI and HIV education in the schools is important, but he did not have any plan for implementation. In fact, he shared with us the official booklet being used to explain sex education policy, *Política de Educación de la Sexualidad*, which blames the "abandonment of traditional morality" on European and North American culture (especially Hollywood), gays, international organizations, and NGOs. He was not aware of a new conservative curriculum being circulated, but did acknowledge that the Ministry of the Family was going to be determining sex education policy and curriculum. He was amenable to alternative suggestions to the curriculum to bring before the Minister; however, while USAID education staff was obtaining alternatives for him in the following days, he was replaced. The issue of sex education controlled by the church is a serious obstacle to HIV–prevention strategies for youth and families.

NATIONAL ASSEMBLY: HEALTH COMMISSION

The meeting was held with Rita Fletes, head of the Health Commission, who has held that position for a year. During the Sandinista government, she was a member of the health brigades, and has taken an active interest in the process of passing the HIV regulation.

In fact, when she saw that the vice minister at the time had no interest in the regulation or HIV, she worked to get signatures to pass it before he could prevent any further action. She had hoped for more consensus on the part of the NGOs in this process. She is concerned at the lack of dissemination of the Law and regulation, which she feels should have been the next step. She has made copies for distribution to NGOs and feels that the ideal strategy would be dissemination by mass media and meetings with youth, but there are few resources for dissemination and she worries that these pieces of legislation will stay in the government and not reach the people. She said that we need mass education to let youth know about the law and also how to prevent HIV. She is concerned about poverty, misinformation, and gangs as obstacles to prevention. She wants sex education in the schools and for it to begin in the fifth grade. She is also concerned about the risk to housewives, and the lack of surveillance data to guide planning.

Ms. Fletes sees an urgent need for materials to support universal precautions in the hospitals, support for the NGOs doing HIV prevention, orientation of physicians, and education for the general population. She would also like for USAID to assist in the dissemination of the law and regulation. She feels that the strategic plan can be modified.

PROFAMILIA

The meeting with PROFAMILIA was more of a discussion with the director, William Baez, than a review of PROFAMILIA's institutional capacity. Mr. Baez expressed serious concern that the government was not addressing HIV/AIDS—that it was not even mentioned in the government's recent study on poverty for donor agencies. He believes that attention should be directed to policy advocacy since the government does not currently believe that HIV/AIDS is a serious problem. He also alerted the team to the ALAFA Project, a new conservative sex education curriculum that has been presented to the ministries, especially the Ministry of the Family, which appears to have been given control of sex education in the schools. He expressed dismay that Nicaragua was "the only country where there is no sex education in the public schools."

PROFAMILIA is currently documenting HIV/AIDS cases in their clinics in Puerto Cabezas and other Atlantic and border locations. They are planning a clinic in Bluefields. They have done a risk study of the military, sex workers, and sailors, and are concerned about the risk for truckers and other mobile populations.

PROFAMILIA clinics (currently 12) conduct STI and HIV testing. All provide counseling; however, the policy is that only doctors can do a positive posttest, which Mr. Baez believes is important (to protect the clinics from scenes that may scare away other clients). The clinics are not using codes for HIV reporting even though they are aware that clients do not like to use their names. He stated that it was "dangerous" for them to market services to high-risk behavior clients because PROFAMILIA is "family oriented." "People come without advertising SIDA, but we need good counseling to protect business..."

They bring men in by offering testing for prostate cancer and have found that 15 percent of older men have prostate cancer. The major method of contraception utilized is minilaparotomy, followed by pills, with very low condom use (3–4 percent). Condom promotion is "a challenge." Mr. Baez was very critical of PASMO (PSI) and said that it did not evaluate the market well. He sees the campaign as too aggressive and strictly urban and was unhappy that PASMO was unwilling "to collaborate" with PROFAMILIA. They now plan to work with DIMECOSA, and will use their 1,280 rural promoters in condom distribution." Our campaign will try to change the idea of the condom to taking care," and will be "directed at youth." "Youth are our primary market." They currently have 5,800 youth organized in clubs around the country.

Both Mr. Baez and the director of IEC, Auxiliadora Lacayo, agreed that it would be good for PROFAMILIA to study the demand for HIV testing in their clinics to establish the profile of those who are coming in for testing as well as to document HIV–positive cases.

CIES

Two simultaneous meetings were held at CIES, with Dr. Pedro Leiva, and Alicia Pineda, director of training. Ms. Pineda explained that the School of Public Health has autonomy within the university; only 40 percent of its funding comes from the university, the rest is from projects. The school has been in operation for 17 years and is the oldest school of public health in Central America. The school belongs to the Network of Schools of Public Health in the Caribbean and Central America, which was formed in 1982, and has held the presidency of this organization.

Ms. Pineda has carried out a number of studies relating to drug use. One study looked at the perception of the educational community about drug education. It was clear, she said, that professionals who teach about drugs do not know about them. None had training, a bibliography, or access to the Internet. Drug education, she found, focused upon effects, not risk factors. She is concerned about these findings, which demonstrate the need for teacher training, and hopes to develop a manual for drug education.

In addition to this study, she has looked at schools in three sectors of Managua, carrying out a survey of 1,500 students regarding alcohol and tobacco use. Ms. Pineda has also obtained

information regarding drug use in Managua, and has police records about the more than 100 drug distribution sites in the city.

She has also assisted students with research projects on drug use in the schools, and has nonpublished information about the children and adolescents in Bluefields. The surveys conducted there with young adolescents show not only knowledge but use of drugs by these children. She and her students are also training nursing students in Bluefields, women who come from indigenous communities and who represent the ethnic minorities of the region. The school in Bluefields, she said, has outdated information and materials in all areas. She would like to be able to support the curriculum of this school, especially in the areas of STIs, HIV/AIDS, and drugs, all issues of critical importance to the Atlantic region. She has graduates all over the country and is willing to use this network for HIV−prevention research and activities. She has already made contact with Fundación Nimehuatzin regarding future activities and training.

MOVIMIENTO MULTIETNICO/BLUEFIELDS

The interview with Eloisa Hudson was held at Fundación Nimehuatzin, the parent organization of this group. The members represent the indigenous and minority populations of the Atlantic region, including Miskito, Rama, and Criollo. The group has been active for two years, having had 12 members, now 6 because of a lack of funding. Two of the members of the group have been trained by Nimehuatzin. They give talks in the community, homes, and churches; provide palliative care to PLWHAs; and, are a resource for prevention education and materials. They are in contact with MINSA staff in Bluefields and refer cases of STIs. Currently, they are providing care to six families affected by AIDS. "We can't do more," said Ms. Hudson, "because we have families [and need income]." Ms. Hudson also works part time for Doctors Without Borders.

CAMPAÑA COSTEÑA

The interview with the coordinator, Ricardo Taylor, was held at CIES, after the presentation of the strategic plan to the NGOs, for which Mr. Taylor had come from Bluefields. He said that they have been organized for two years but have been working since 1991 with support from Swiss donors under the direction of Mark Eisler, an epidemiologist working with MINSA in the area of STIs. Paid staff includes two full-time educators in addition to him. Three others work with them: a student, a promoter, and a female outreach worker. They have had some support from TESIS and are in communication with the Comisión Nacional. Both NGOs have sent materials and individuals to assist with special activities. Their focus is mainly on prevention, he said, working with youth through painting and theater groups. They have also held workshops on prevention and self-esteem with help from MINSA and Doctors Without Borders. The organization also works with other groups in Bluefields on related activities, such as drug prevention. They distributed condoms obtained from MINSA

but are now distributing VIVE condoms. They have had time on five radio stations, but will be reduced to two when Canadian funding ends this month.

Mr. Taylor stated that they need funding to work on Corn Island, where drugs and tourism create conditions of risk for the population, and to continue their radio programs. He feels that they have a special role and potential because they understand the cultural differences of the area, a factor that has prevented other programs and projects from working there. A cultural understanding, he explained, must be a part of all aspects of projects for this area, which is home to Garifuna, Miskito, Rama, Criollo, Mestizo, and Mayagna communities.

CENTRO MUJER Y FAMILIA (CMF)

The director of this NGO, Xanti Suarez, is an extremely influential woman who is a member of the PARLACEN and who has direct linkages with high government officials. She is a member of the Comisión Nacional (a coalition of NGOs) and a media/publishing professional. Ms. Suarez described the NGO as having 12 voluntary staff. It has been funded for 10 years and works in four major areas: health and nutrition, legal and policy issues, psychosocial issues, and promotion, training, and research in health. It has doctors, psychologists, lawyers, social workers, an administrator, an accountant, and a secretary on staff. Currently, they are focused on three areas: victims of domestic violence, breastfeeding, and HIV/AIDS prevention. She stated that they played an important role in the formation of the Comisión Nacional as well as in the process of negotiating the HIV regulation (for which they received money from PASCA). They conduct workshops on HIV/AIDS prevention in five Managua barrios as well as the communities where they are working on their breastfeeding initiative. Ms. Suarez says she is currently working on the passage of a law for safe blood and blood products in connection with the HIV law [the regulation deals specifically with HIV; the law is a human rights law, so this statement is not clear].

She also spoke about the strategic plan and said that it is an accomplishment after a two- year delay. She expressed great concern that MINSA has not played a larger role in the plan and believes that it needs more “political commitment” and “highest level visibility.” She said that the plan has a strong communication component and cannot be reduced to pamphlets. Recognizable public figures must speak on television to promote HIV prevention. She is currently working with Rita Fletes of the National Assembly to get the Health Commission to meet with the Commission of the PARLACEN. She is concerned about what will happen to the plan in two years when the government changes. She also sees the need for a good evaluation of the implementation of the plan. She sees the need to teach the authorities who think it is still a homosexual issue. The budget of the plan, she says, is not adequate, and she worries about a political environment that denigrates NGOs.

CMF buys condoms from PASMO and sells them. Its funding had come from the Norwegians as well as AIDSCAP (in 1997) and PASCA last year—it was one of the three

priority NGOs for PASCA. As part of a five NGO coalition created as a funding mechanism by the Norwegian Agency for International Development (NORAD), she complained that this is a "headache" because each NGO has a "different level of development and commitment," with different realities.

This was an interesting interview given the multiple roles played by the director. It was not always possible to distinguish her roles from the activities of the CMF.

FUNDACIÓN NIMEHUATZIN

The team met with executive director and founder Rita Arauz, and her staff, Pascual Ortells and Georgina Ruiz. This agency was the first AIDS NGO established in the country in 1990. The organization's work, however, began with CEPSIDA, before the first case of HIV/AIDS was documented in 1987. It remains the only AIDS–dedicated NGO and directs efforts at policy and human rights as well as research, training, and education in prevention and care. It has carried out research on high-risk behavior populations (with Family Health International [FHI] and other institutions) as well as research with university students (without funding). It has developed sophisticated training materials for professionals and NGOs (Medicus Mundi/United Nations Development Programme [UNDP]) and currently is training SILAIS staff around the country. Its educational materials, videotapes, and posters are directed towards all sectors of the population and are used widely within the country. Nimehuatzin was instrumental in the formation, lobbying, and passage of Law No. 238. The Foundation has fostered the formation of the Red de Etíca, the Red de Comunicación, and the Red Comunitaria and continues to provide technical assistance to those networks that are not members. The documentation center, which has no current funding and crowded space, has over 6,000 items, updated journals and a policy of user orientation. The archivist/librarian is extremely knowledgeable about HIV and STIs and has trained other documentation center staff in the country and the region. Their magazine, *DE SIDA*, has timely articles and information and will be disseminated regionally. The Foundation works to promote HIV/AIDS within a development perspective, believing that AIDS is a problem of development, not a health problem. They are working to change the medical model to a more expansive model with increased emphasis on geopolitical, cultural, economic, and behavioral aspects of HIV transmission and infection. They are not members of the Comisión Nacional de la Sociedad Civil and were not contributors to the strategic plan. They are part of the leadership of the Latin American and Caribbean Council of AIDS Service Organizations (LACCASO) and the International Council of AIDS Service Organizations (ICASO) and consultants to UNAIDS and the United Nations Development Programme (UNDP), among others.

THE NICARAGUAN NETWORK FOR COMMUNICATION AND HUMAN RIGHTS IN THE FACE OF AIDS (RED NICARAGÜENSE DE COMUNICACIÓN Y DERECHOS HUMANOS ANTE EL SIDA)

This interview was held at Fundación Nimehuatzin with Maria Elena Artola Juarez, who was one of the founders of the network three years ago. She stated that the network, which has no central coordination, has approximately 60 members associated with it, but only 30 actually attend meetings. These members are media professionals (print, radio, and television) who want to specialize in the issues of HIV/AIDS and human rights and those interested more simply in keeping abreast of these matters as part of their sociopolitical reporting. The network began when Nimehuatzin invited representatives of the media to meet to inform the public about HIV/AIDS, and the Fundación continues to act as technical adviser. The network's aim is to facilitate access to and sharing of information about HIV/AIDS among the media—a professional exchange network, rather than a closely interactive social arrangement.

This group has produced materials with AIDSCAP funding and has placed information on HIV into two permanent radio programs, which are broadcast five days a week. Its radio spots have also been used in schools and universities. Its current goal is to obtain funding to have a regular call-in program on a national radio station that broadcasts to other countries in the region as well. The staff plans to document the questions and answers for an annual publication to be used for prevention education. The team listened to the spots during the interview and found them to be clear, informative, and professional.

THE COMMUNITY NETWORK FOR HUMAN RIGHTS IN THE FACE OF HIV/AIDS (RED COMUNITARIA DE LOS DERECHOS HUMANOS ANTE EL SIDA)

This network is co-coordinated by Nimehuatzin and a women's NGO, Casa de la Mujer Sonia Bello. It builds on the growing base of organizations trained by Nimehuatzin, different NGOs, and community-based organizations working with different types of communities (youth, sex workers, women and gay collectives, truck drivers, and industry workers) and on different aspects of HIV/AIDS prevention. The Community Network thus serves as a means for activists to share experiences, expertise, and moral support. As such, it serves as a capacity-strengthening network aimed at using the exchange of mutually compatible experiences and philosophies, but different knowledge and skills. Consistent with this purpose, the network is managed in an open way with no stated dates for its development; activities evolve as the members' expression of need, interest, and growing capacities warrant.

Based in the communities of its member organizations, often themselves local networks, this network is to some degree a network of networks, a fact which increases both its potential for inclusion and the challenges of communication within it. Limited funds have prevented frequent meetings (much of the work of the NGOs themselves is voluntary). The hope, however, is that with its rising profile as a national networking base, it will be able to mobilize government and donor links and generate the resources needed to strengthen and give stability to the community work of its members. A critical balance for this network is in increasing the number of its member groups (to gain "critical mass"), while maintaining the direct ties with local people, which is its particular strength.

XOCHIQUETZAL

The meeting at Xochiquetzal was attended by the executive director, Hazel Fonseca, Diana Cordova, physician, and Lesbia Gutierrez. This NGO was begun in 1990 to reach lesbian and gay populations, but now works with other groups, such as prisoners, youth, and PLWHAs. It has a full-time staff of 50, of which 32 are in Managua, with goals of education, service, and research. Gender and violence are a permanent focus. They have conducted research on high-risk behavior groups with ILPES, and are currently completing a survey designed and funded by FHI. They have conducted small HIV surveys (diagnosticos) before interventions in Matagalpa, Jinotega, and Esteli from 1995–99. They are doing outreach to communities in the North and use a network of promotoras as well as radio spots to promote HIV prevention. Fifteen promotoras are in five cities working full time with women's groups and in the community (barrios). They also work with lesbian groups to promote self-esteem. Their hotline is operational for 12 hours, Monday to Saturday. Xochiquetzal also publishes a magazine, *Fuera del Closet*, in addition to producing posters and educational materials. They helped to organize and provide space for the Red de Gente Positiva, although they are not currently involved in their activities. Medical and laboratory services are located at the Managua site where testing and counseling are conducted and medicines are prescribed by the physician. They are currently focusing on working with the dying process, conducting a support group, and incorporating spirituality in these efforts. They see priority needs as strengthening MINSA's commitment, reinforcing CONISIDA, working against the sodomy law, supporting appropriate sex education efforts, training health personnel, providing health personnel materials to guarantee their safety, and supporting a mass educational campaign. The strategic plan, they said, was "already completed" when they were invited to participate; "it was done upstairs."

RED DE GENTE POSITIVA

Only the coordinator, Sergio Navas, was available for this meeting, partly because the participants are fearful of meeting with people. Apparently 12 individuals are part of this "network," but few attend meetings.

They are in contact with infected individuals from other cities, but they will not come to meetings. He believes there are many people who are infected and sick but they will not come for help. “People die in their houses,” he said.

The Red really only functions as a support group. It was not permitted to participate in the Comisión Nacional, and was told that it had to be a member for four years before it could vote. It is not part of the Red de Etíca. “We are not represented in the strategic plan,” he noted. While Xochiquetzal provides the organization with space, the room is inadequate for its needs, especially for any relaxation exercises or workshops.

Sergio presented the serious situation of PLWHAs in the country:

- there is no money in the national budget for HIV or AIDS,
- no hospital will accept people with AIDS,
- referrals are not made because there is no place to which to refer patients,
- “money for projects stays with the projects—we get an aspirin,”
- “people won’t show their faces—there is no reason to do so,”
- prophylaxis is at the whim of an individual physician—they have no right to these medications, and
- medicines are sent from friends in the United States—if they run out, they try to get supplies from Nimehuatzin.

COMISIÓN NACIONAL DE LUCHA CONTRA SIDA DESDE LA SOCIEDAD CIVIL

While the team expected to meet with Esperanza Camacho to represent this organization, the meeting was attended also by Marilyn Mora and Xiomara Luna (Si Mujer), and was run by Leonel Arguello.

Dr. Arguello provided the team with the history of institutional change in the country with the revolution and succeeding governments, as well as attitudinal change in the population (“sexual revolution with Revolution”) and said that the 1960’s in Nicaragua came in the 1980’s. He discussed the noncommercialization and control of the blood supply as an important factor in controlling the spread of hepatitis B and HIV. He stated that with the revolution, “prostitution disappeared because women had work,” including brothels. Now, he said, all types of prostitution exist. He believes, however, that Nicaragua is “an island in

Central America" with a "different epidemiological picture." "We have a delayed epidemic," he stated. The issue of condoms, he believed, was the irresponsibility of the government bowing to church pressure, "retrazo y timidez." In addition to MINSA, he blames the Ministry of Education and its control by Opus Dei. The popular acceptance of condoms "has been a labor of many years," but they are not getting to the higher risk. He believes access and perception of risk must be fostered at the same time.

The Comisión is promoting "cambio de conductas," using the cadena de cambios. The three groups already trained by PASCA in this strategy are Xochiquetzal, CEPS, and Si Mujer, and they have used it with adolescents in the North. The fundamental role of the Comisión is to keep the NGOs together. They have 84 organizations, some having years of experience, some just beginning in AIDS—"we need to train the NGOs." "Neither the government nor NGOs is enough." He stated that the Comisión is filling the space that the government is failing to fill, although at the local level, "we work well with MINSA." In addition, he cited the government as "anti–NGO." "It is now important to support the renewal of CONISIDA.

They want to see money invested over time, "not just one shot," and believe that it is important to reach a mass audience with television and radio as well as the cadena de cambios—"messages should come from all directions." Funding should be directed at condom access, a permanent HIV–prevention campaign at all levels, the standardization of NGO capacity, promotion of the law and regulation, and research. Research should be concentrated in CISAS, he said, because it has the documentation center— "everyone uses it." Research needed includes why there is a lack of condom use and evaluation of the effectiveness of messages. MINSA needs support in training and biosecurity.

Regarding the strategic plan, Arguello stated, "We know the plan has serious enemies." PASCA wanted to start from the beginning without realizing our existing plan," but gave "bastante apoyo técnico." "PASCA came to define what a strategic plan is and the methodology."

CEPRESI

In a poor barrio, at a distance from the city's more central areas, the team met with the staff of this relatively new NGO, the only one with exclusively gay male identity. The site was in the process of refurbishment and was bright and spacious with posters on the walls. Two men were there at the time, but were not introduced to the team. The director, Norman Gutierrez, had been associated with the original voluntary gay-identified HIV–prevention organization in the country, CEPSIDA, in 1988. He described various iterations of gay groups with different names and memberships, and stated that CEPRESI became a legal entity in 1995 but received its first funds in 1998 from Dutch donors. CEPRESI is a member of ASICAL and the Comisión Nacional as well as ARCEGAL. Mr. Gutierrez stated that their goals are to promote tolerance of sexual minorities, to have Article 204 of the Penal Code abolished

(sodomy clause) and to educate gay men and women about legal and legislative issues and human rights. He stated that they have promoters in cities throughout the country and a network of 150 men with whom they carry out groups. Their training content was not reviewed, however, and they have not received technical assistance for these activities. The director of training has had no professional education.

CEPRESI staff has attended numerous international meetings and has just finished a training program by PASCA. They have signed a contract with PASMO to distribute VIVE condoms. They have not yet begun to work with travesti, nor have they been able to work with the gay discos in Managua. Mr. Gutierrez stated that one of their main concerns is that gay men will not seek services because of the stigma of being gay and HIV positive and will self-medicate instead. He also feels that they should be able to give out free condoms as their target population has a low level of education and thus high unemployment. "We don't have a culture that uses condoms," he said, "and so we have double obstacles."

CISAS

CISAS was established to carry out health promotion within "salud integral." The priority of CISAS since 1990 has been STIs/HIV/AIDS, principally in prevention. It is currently working in 22 communities in five departments, including Managua, and with a number of networks. It works on a permanent basis in some communities and is activity-based in others, depending upon the level of need (deterioro), accessibility, and existence of "some level of organization." The organization forms part of the Executive Committee of the Comisión Nacional. The NORAD consortium, of which it is a part, was described as "una belleza." When asked about the strategic plan, it was stated that PASCA facilitated technical assistance to the Comisión Nacional. The respondents agreed that the issue of human rights does not need to be included because "everything relates to human rights [anyway]"; it does not need to be stated in the plan because of the Red de Gente Positiva and Law No. 238. (They stated that they were not aware of any human rights network in the country.) They believe the plan is "bastante completo" and that "laws above the plan will regulate where funds go."

CEDOC

CEDOC, the communications center that is part of CISAS, was funded in part by PASCA and houses the PASCA country representative. It has seven full-time staff and three part-time staff. The team was told that the center has 600 volumes on HIV/AIDS, 200 videotapes, and 40 magazines and pamphlets. On closer inspection of the resources, there were only three and a half short shelves of volumes on any aspect of HIV and 334 registros; most were from the 1980's, with some from the early 1990's. Only one volume mentioned antiretrovirals, and that was the World Health Organization (WHO), 1997. The 25 references on treatment were not only outdated but referred mostly to the African experience. They had no way to pull up

any of the recent articles requested nor did they have most of the AIDS journals. The assistant who took one of the team members around was not trained sufficiently to manage requests efficiently nor was he trained in the orientation of center users. This is a seriously deficient institution in content, ability to access recent material, and staff training (there has apparently been much staff turnover and change of documentation format).

ORGANIZACIÓN INTERNACIONAL PARA LAS MIGRACIONES (OIM)

The team met with Ivan Davalos, the new director, and Beatriz de Briones, who has been with OIM for many years. The organization is concerned with issues of migration and has been operating since 1975 under different names. Its association with the United Nations is "voluntary," and it is funded largely by bilateral agreements. OIM always works through government channels, and has worked with migration related to war, including assistance to repatriating professionals. Hurricane Mitch, they stated, caused a different kind of population movement, an internal migration. In 1999, they signed an agreement with WHO to work on HIV/AIDS issues. The organization also belongs to the Grupo Temático of UNAIDS. It has a field staff of 15–20 and tries to identify regional groups with which to work. Currently, OIM has presented a proposal for working in Bluefields on the relationship between labor migration and HIV/AIDS in Bluefields.

Davalos and de Briones agreed that the topic of migration is a sensitive one, and they have received little government support or interest, especially in their desire to carry out a census to study outmigration. They do not have information on mobile populations, only projections.

They have not yet seen the strategic plan.

The director is concerned about the truckers in the area of Guasaule ("the topic of AIDS still carries great stigma"). He also believes that there are few organizations willing to work on the Atlantic coast (RAAS) because it is expensive to travel and work there. PASCA has offered assistance to give workshops there, and they will be coordinating with PASCA. They would like to propose ideas to USAID, and to continue to work with Alberto Araica. They had received emergency Mitch funds from USAID, but said these were temporary, emergency funds and that they have had no historic link with USAID in Nicaragua as they have had in other countries, such as Honduras. Their message to USAID was "use us, we have expertise and experience in all that is migration." They are currently discussing the Bluefield's proposal with USAID and Nimehuatzin.

DAMAS DIPLOMATICAS

The wife of the Peruvian ambassador and her physician consultant, Dr. Juan Cordoba, described the role of the organization, which is comprised of the wives of the diplomatic core and international agencies. It has been in existence since 1994 and registered as an NGO in

1998. Their activities are primarily involved with children and the elderly, supporting various hogares. They distribute approximately $4,000 a month. Recently, they began helping to cover laboratory analyses and medical attention for elders. Since 1998, they have been helping PLWHAs with medicines for opportunistic infections, and will have their first meeting with other NGOs serving the HIV community in April. They have been in contact with PASCA for technical assistance as well as PAHO. Currently, they appear to have been convinced that they need to carry out a study on the economic impact of AIDS in Managua in order to justify funding for a type of hospice, which is the president's mission and may be their principal HIV/AIDS activity. It is not clear why they believe that they need to do this nor is it clear how they will obtain funds or implement the study. It is also not clear how they will be able to administer and staff the large facility that houses the group and will serve as the hospice. The physician guiding this effort is inexperienced, and the Peruvian model being used may not be appropriate for the country. There are serious issues here relating to the appropriateness of the goals for this organization, especially since few of the members appear to be supporting this effort.

PASMO

PASMO staff members met with the team at their offices (Marlon Elias, Richard Ayala, and Carolina Ramirez) and discussed their goals and current activities. PASMO's goal is to provide products at low cost and to increase the accessibility of condoms for high-risk behavior groups: MSM, gay men, sex workers, military personnel, PLWHAs, and adolescents. They are attempting to establish strategic alliances with 12 NGOs. Distribution points are traditional sites (pharmacies), nontraditional sites (liquor stores, supermarkets, motels, and gasoline stations), and high-risk sites (brothels, discotheques, gay bars, and the stroll). They reported more than 500 traditional sites, 100–120 nontraditional sites, and 25–30 high-risk sites. (However, when checked by the assessment team, no condoms were found at the only currently open gay discotheque.) The team was told that free condoms are not a good strategy because people do not trust or value free things; condoms are sold at 3 cordobas per 3 pack. They report 180,000 sold, 70 percent of the condom market. VIVE is the only condom on television and the only condom the team observed on billboards. They are doing training that includes HIV to promoters from the NGOs. Competition will now be coming from DIMECOSA and the Bodyguard brand of condom.

PEOPLE LIVING WITH HIV/AIDS (PLWHAs)

Drs. Sánchez and Shedlin carried out four interviews with individuals living with HIV and AIDS to elicit some of their perceived resources and obstacles to prevention and care. They interviewed gay and heterosexual men and a housewife now working with the Red de Etíca. The interviewees presented different risk histories but many of the same concerns. These concerns reflected the lack of information about HIV/AIDS, scarce or negligible resources available for prevention or care, and the serious breeches of professional ethics and

confidentiality in their care. They spoke of feeling scared, isolated, and alone. They hid their status and disease even from close relatives and providers, even though they are now involved in advocacy and prevention, empowered by NGO efforts and support.

A 19-year-old man from Masaya told of living in Managua to hide his HIV from his family. He spoke about having his test results sent to MINSA by an NGO with all his identifiers; his confidentiality and rights were ignored. He spoke about many poor people he knew with HIV who had neither care nor sufficient food.

Another interviewee, a 33-year-old housewife, stated that she "no longer has any tears left" after her experiences in seeking care. She was pregnant when she was tested and was refused a C–section because she was HIV positive. She said her baby was "pulled out like an animal," breaking her pelvis in the delivery. In the nursery, her baby's name was preceded by a sign that stated, "Restricted, Mother SIDA." When she was well enough to bring the baby home, it was dehydrated and sick from lack of care in the hospital nursery. As she described the lack of help outside of the NGO which cared for her, "MINSA shines by its absence" ("MINSA brilla por su ausencia!").

A 28-year-old gay man discussed his quest for services in Nicaragua and Costa Rica, especially in seeking medications for his opportunistic infections. His only help came from a private physician and an NGO. He particularly mentioned the lack of conscience of the laboratories that charge high prices for testing.

If these brief and limited interviews can add anything to understanding the situation, it is in illustrating the critical need for additional testing services, counseling, hospitals that will accept HIV–positive patients, providers who are trained and sensitive to caring for HIV–positive patients (and in universal precautions), training in confidentiality and human rights, and the provision of counseling and survival needs of HIV–positive individuals. They illustrate the need for support to MINSA in accepting a responsibility for prevention and care and the inequity of expecting underfunded NGOs to carry the prevention and care burdens of the epidemic. They also illustrate impressively how HIV–positive individuals with minimal medical care and a great deal of emotional support and empowerment through NGO efforts can become educators and advocates, fighting for their own survival and carrying out advocacy and prevention in their communities.

UNDP

Monserrat Anguello described her office as a focal point for HIV/AIDS, although, she said, HIV is not an official part of their planning given the mandate of UNAIDS. They are currently working with a new administrator, redefining strategies and policies. "We have done little in HIV/AIDS," she said. Their only direct activity is with Fundación Nimehuatzin,

cofinanced by New York and Managua. She is planning to be in more frequent contact with USAID (Alberto Araica) in the future.

UNAIDS

A meeting was held with Dr. Ninoska Salazar, national advisor to UNAIDS. She was concerned with the implementation of the strategic plan and how UNAIDS would be able to help. One of her suggestions was support for a local advisor to assess the resources available for HIV/AIDS through the United Nations system and the NGOs. The main obstacles to prevention that she saw were the controls of the church, especially on the Ministry of Education for sex education, and the scarce resources in MINSA.

She was concerned with the version of the strategic plan, which had nothing on human rights ("lost the perspective on human rights") and nothing on STDs. She was concerned that PASCA had put an operational plan into the strategic plan. She believed that a technical revision of the plan was in order, especially since the technically qualified people and the experts had stayed out of the process because they did not want to be involved with "differences." However, she was concerned that the people responsible for it had not wanted to be "corrected." She was also critical of the presentation of the plan and believed that it should not have been the Comisión Nacional presenting it, but MINSA.

HOSPITAL BERTA CALDERON/ADOLESCENT CLINIC

The waiting room of the clinic was bright and filled with educational materials (United Nations Population Fund [UNFPA], PROFAMILIA, Si Mujer, and Nimehuatzin). A few people were waiting to be seen, including a young man. An AIDS prevention video (Nimehuatzin) was playing in the waiting room. The visit was with Dr. Ximena Gutierrez, and the team was introduced to numerous professional staff. The clinic was begun in 1995 with funds from UNFPA. It offers prenatal care, family planning, STDs, Pap smears, and counseling. The program also does follow-up outreach to homes and trains adolescent leaders to work with their activities.

This clinic offers the only differentiated care for adolescents in the country and "the demand is great." It has over 10,000 visits a year and approximately 800 a month; 98 percent of the consultations are with young women. Prevention education is coordinated with NGOs. Staff training in HIV was conducted by Nimehuatzin, including the social worker. HIV testing is not conducted but patients are referred to MINSA or Nimehuatzin.

Adolescents who come for services are enrolled in three groups: STDs/HIV, pregnancy prevention, and prenatal care. Adolescents see the same doctor each visit. STD medicines are free and condoms are obtained from UNFPA. It has no laboratory to test for STDs and no pharmacy and additional materials are needed for prevention education in reproductive

health and HIV. Dr. Gutierrez is currently working on a manual for counseling of adolescents in sexual and reproductive health with MINSA and UNFPA. Staff is currently involved in research on family violence, without funding or technical assistance.

DR. GUILLERMO PORRAS, INFECTIOUS DISEASE SPECIALIST

Dr. Porras was identified to the team by many of the individuals and agencies during the interviews. There was a clear consensus that this physician, dismissed from the MOH Hospital for political reasons, was the leading caregiver known to the HIV/AIDS community. It was a unanimous opinion that this man was willing to treat anyone with compassion and expertise while at the hospital, and now in his own private clinic.

Dr. Porras described a dire situation with regard to HIV in the country. He said there was "no HIV/AIDS culture," that people were phobic about AIDS and saw it as a problem unrelated to their own lives. He used the words "terrible panic" to describe people's reactions. He confirmed the common belief that the government has no commitment to AIDS prevention. However, he was able to identify numerous individuals and organizations prepared to support prevention and care efforts that are not being involved in any way. Among the individuals he mentioned were Cecilia Trinidad (Asociación de Médicos Nicaraguences) and Maricio Barrios, trained in France. A third doctor, a pediatrician trained in Mexico, was also mentioned.

Dr. Porras is very concerned about the contact tracing mentality of the MOH and the lack of confidentiality of records. He believes that Dr. Roman "is controlled from above" and that she is not free to develop policy or programs. When he was working with the MOH, he initiated many efforts to make health care workers sensitive to the issues of HIV and PLWHAs, including having PLWHAs deliberately hug him in the hospital hallways. Now that he is no longer at the hospital, he has had to develop clandestine ways to have PLWHAs admitted through his network of colleagues and students, a strategy he calls his red de complicidad.

His discussion of antiretrovirals and other HIV medications revealed his concern about the lack of availability. A few patients have relatives in the United States who send them medications; some have help from NGOs. There is, however, a growing illegal market for antiretrovirals, he noted. Many PLWHAs were in Costa Rica; they go back, obtain medications, and sell them in Nicaragua. He is also concerned about these drugs not being prescribed appropriately, and cited an NGO where the doctor did not accept his advice. A new doctor in that NGO has corrected this problem; however, the lack of training of medical personnel as well as unwillingness to treat PLWHAs is a serious concern.

CRUZ ROJA DE NICARAGUA/CENTRO NACIONAL DE SANGRE

The Nicaraguan Red Cross, through its blood bank, captures 70 percent of blood at the national level. The remaining 30 percent is captured through government institutions (MOH). Since 1987, the Red Cross carries out an obligatory screening of blood banks for HIV, hepatitis B and C, Chagas illness, and syphilis. According to Dr. René Berríos, "counseling for HIV–positive patients provided by the MOH is not the ideal one." According to Red Cross statistics, there are 3–4 patients confirmed as HIV positive for every 10 Elisa tests. This shows that the epidemic is increasing among blood donors. The Red Cross has two current priorities: first, to strengthen infrastructure for public screening centers, and second, to guarantee safe transfusions with higher coverage.

FEDERACIÓN NICARAGÜENSE DE ONGS

The NGO Federation, headed by Ana Quiroz, director of the Health Information, Services and Advisory Center (CISAS), said that the organization was founded in 1983 with the objective of providing popular education in health. Its work areas are institutional strengthening and donations.

ASOCIACIÓN DE MUJERES NICARAGÜENSES "LUISA AMANDA ESPINOZA" (AMNLAE)

The objective of this organization is to transform the disadvantageous conditions in which Nicaraguan women live. This Nicaraguan NGO provides coverage with its different services throughout all municipalities in the country. Its main programs are integrated health, legal support, political participation, education, and organizational and economic development. The integrated health activities are implemented through 58 casas de la mujer, 28 health clinics and 4 casas maternas, or mother houses, with young women and teenagers as the main beneficiaries since the focus of the interventions is education for the prevention of STIs. At the casas de la mujer, they provide gynecological clinical services; casas maternas are shelters for pregnant women. AMNLAE's director, Dora Zeledón, told the team that they "do not know the national strategic plan for the prevention of STIs/HIV/AIDS, and that there are not members of the National Commission in the Fight Against AIDS, since it does not solve anything for them at the local level." Other organizations that have coordinated some activities are CISAS, Nimehuatzin, and Xochiquetzal. Among their current priorities are the strengthening of the STD component in clinics, increasing the community education promoters network, and supporting urban and rural networks.

TESIS

This NGO emphasizes self-esteem, human rights, the empowerment of women, public influence, and prevention of HIV/AIDS. Beneficiary groups are female sex workers,

children, and adolescents. It covers about 700 women in 12 workplaces, and coordinates actions with the MOH and PROFAMILIA. Some of the achievements to date are medical care for female sex workers through a strategy of pre-paid bonuses by the Central American Health Institute (ICAS), promotion of condoms among vulnerable populations, and greater awareness of women about their rights. TESIS financing comes from Dutch donors, (NOVIP), Switzerland, and Germany (GTZ).

APPENDIX E

DOCUMENTS REVIEWED

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APPENDIX F

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